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A.M.L. v. Utah Department of Health : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

A.M.L. Petitioner, v. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	Case No. 920595-CA Category No. 14

BRIEF OF APPELLANT

This is an appeal from the "Final Agency Action" of the Utah Department of Health, Division of Health Care Financing, Rod Betit, Director (Interim Executive Director, Utah Department of Health), dated August 10, 1992, in Case No. 91-156-02.

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JURISDICTION OF THE COURT OF APPEALS

This is an appeal from the "Final Agency Action" of the Utah Department of Health, Division of Health Care Financing, Rod Betit, Director (Interim Executive Director, Utah Department of Health), dated August 10, 1992, in Case No. 91-156-02. Jurisdiction is proper pursuant to Utah Code Ann. § 63-46b-16 (1989); Utah Code Ann. § 78-2a-3 (Supp. 1992). (This is a petition for review of an administrative agency action having the priority of argument designated under Rule 29(b)(14) of the Utah Rules of Appellate Procedure.)

STATEMENT OF THE ISSUE

Whether the Utah Department of Health, Division of Health Care Financing ("DHCF") erred in denying the application of the Petitioner-Appellant ("A.M.L.") for prior authorization of Medicaid coverage for bilateral breast reduction on the basis that it was a non-covered service and was not medically necessary?

STANDARD OF REVIEW

The standard of review is whether, on the basis of the agency's record, A.M.L. has been substantially prejudiced by the agency's action. Utah Code Ann. § 63-46b-16(4) (1989). The

correction-of-error standard of judicial review applies to agency decisions involving issues of law and no deference is extended to agency rulings. Agency findings of fact are accorded substantial deference and will not be overturned, if they are based on substantial evidence. Hurley v. Industrial Commission, 767 P.2d 524, 527 (Utah 1988).

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES

42 U.S.C. § 1396 (1988).

42 U.S.C. § 1396d(a) (1988 & Supp. II 1990).

42 U.S.C. § 1396a(a)(5) (1988).

42 U.S.C. § 1396a(a)(17) (Supp. II 1990).

42 C.F.R. § 440.230(c) (1992).

(See Addendum for copies of these provisions.)

STATEMENT OF THE CASE

A. Nature Of The Case

A.M.L. was denied prior approval for breast reduction surgery ("reduction mammoplasty") because it was deemed a cosmetic or non-covered service. (Record (hereinafter "R") at 88.)

B. Course Of The Proceedings

On appeal to a hearing officer, a Prehearing Conference was held on June 19, 1991. (R. at 5.) A hearing was held on August 9, 1991. (R. at 9.) The hearing officer recommended that the decision of DHCF to deny A.M.L.'s request for reduction mammoplasty be affirmed. (R. at 87-89.) An "Interim Agency Action and Remand" was issued on November 18, 1991, remanding the case to the presiding officer to obtain recommendations from a DHCF physician consultant regarding the medical necessity of A.M.L.'s requested reduction mammoplasty. (R. at 85-91.) The DHCF physician offered the opinion that the requested service was not medically necessary. (Respondent's Exhibit 2 at 1-2.) A.M.L. submitted an objection to the DHCF physician's opinion. (Petitioner's Exhibit 12.) This objection was overruled. (R. at 96-99.) A second hearing was requested in order to cross-examine the DHCF physician. (R. at 100-101.) This second hearing was held on July 21, 1992. (R. at 109-175.)

C. Disposition At Trial Court Or Agency

A.M.L. received an unfavorable Final Agency Action dated August 10, 1992. (R. at 196-205.) Medicaid assistance having been denied at the agency level, this appeal followed. (R. at 186-88.)

D. Relevant Facts With Citations To The Record

A.M.L. is 28 years old. (See Petitioner's Exhibit 1 (letter from David C. Flinders, M.D.)) In the fall of 1982, at age 18, she developed symptoms of joint pains and was found to have a positive ANA test indicating Lupus Erythematosus. (R. at 17; Petitioner's Exhibit 1.) Lupus is a chronic, inflammatory disease in which the body's immune system, instead of serving a protective function, forms antibodies that attack healthy tissues and organs. (Petitioner's Exhibit 7; Petitioner's Exhibit 13 at page 15 (Harrison's Principles of Internal Medicine 1432 (12th ed. 1991.))) It can affect the blood, skin, joints, kidneys, brain, heart, lungs, central nervous system and connective tissue. (R. at 26; Petitioner's Exhibit 7.)[1] Available evidence indicates that lupus is inherited. (Petitioner's Exhibit 7.) It is an incurable disease and eventually results in death. (R. at 20-21, 27; Petitioner's Exhibit 7.)

The amount of inflammation associated with the lupus is sometimes measured in terms of the sedimentation rate (rate of "sedding" of the red blood cells over a period of one hour). (R. at 48.) Sometimes A.M.L.'s sedimentation rate has been up to 69,

[1]A.M.L. has experience problems with all of these.

other times as low as 2. (R. at 47, 57; see also Petitioner's Exhibit 9.)

Steroids are used to prevent the disease from getting too severe too quickly. (R. at 21.) When the sedimentation rate is lower, less steroids are required. (R. at 46.) A.M.L. was placed on Prednisone (a steroid) for control of her lupus. (R. at 9, 21; Petitioner's Exhibit 1.) She required continuous administration of Cortisone' type products, resulting in a weight gain of 66 pounds. (Petitioner's Exhibit 1.)[2]

Along with the weight gain she has had a substantial increase in her breast size[3], which, in turn, has lead to chronic neck and back problems. (R. at 30-31, 40, 66; Petitioner's Exhibit 1; Respondent's Exhibit 2 at 8 (letter from Charles V. Pledger, M.D., July 1, 1991.) See also R. at 125 and Petitioner's Exhibit 13 (backache is a symptom of breast

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[2]Eventually A.M.L. was requiring extremely high doses of Prednisone, but it wasn't effective in controlling the lupus. (R. at 19.) Consequently, she was given a combination of Prednisone and Imuran (an anticancer drug that caused her to lose her hair temporarily). (R. at 20.)

[3]She has about 800 to 1,000 grams of excess breast tissue per side. (R. at 69; Petitioner's Exhibit 2 (letter from Charles V. Pledger, M.D., March 5, 1990); Respondent's Exhibit 2 at 8 (letter from Charles V. Pledger, M.D., July 1, 1991.)) Her bra size has gone from 36B to 44DD. (R. at 64.)

hypertrophy.))[4] A.M.L. has lumbar disc disease and the heavy breasts contribute to this problem as well. (Petitioner's Exhibit 13 at 11.) In addition to her back problems, she has painful grooves from her bra straps and during the summer she gets severe yeast infections and ulcerations under the breasts. (R. at 42; Petitioner's Exhibit 2; Petitioner's Exhibit 13 at 11; Respondent's Exhibit 2 at 8. See also R. at 125 and Petitioner's Exhibit 13 (intertrigo is a symptom of breast hypertrophy.)) She has huge stretch marks, which are really painful. (R. at 29-30.) She experiences kidney stones and headaches as well as numbness in her arms and hands. (R. at 32, 38, 41-42, 58-59, 62, 66, 69; Petitioner's Exhibit 13 at 11.) Her condition also affects her breathing. (R. at 62; Petitioner's Exhibit 13 at 11. See also R. at 125 and Petitioner's Exhibit 13 (respiratory difficulties are symptomatic of breast hypertrophy.)) Her treating physician feels that her symptoms have been "in large part due to the steroids that she must take chronically for her Lupus Erythematosus." (Petitioner's Exhibit 1. See also Petitioner's Exhibit 13 at 11 (back, neck, and shoulder aching, grooves in shoulders, lumbar disc disease, ulcerations beneath

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[4]A.M.L. has found that, no matter how hard she tries, it is impossible to lose weight while using Prednisone. (R. at 53.) Even if she did lose weight, it is doubtful it would tighten up her loose skin. (R. at 54.)

breasts, numbness and breathing problems, all result from large breast size.))

Before she started using Prednisone, A.M.L. had a fairly-active, normal life. (R. at 28, 66.) Her activities have slowly decreased down to a point where they now consists of being in the house, doing handicrafts, watching TV and taking journalism home study courses. (R. at 28-29.) She is fatigued all the time and that plus the weight gain has been devastating on her self-esteem. (R. at 28.)

Because of the pain and discomfort from her large breasts, A.M.L. sought referral for a reduction mammoplasty. (Petitioner's Exhibit 1.) A plastic surgeon concurred that she would likely benefit from this procedure. (Petitioner's Exhibit 1.) Her treating physician said that, in his judgment, A.M.L.'s motivation for reduction mammoplasty is not for cosmetic reasons, but for medical reasons including relief of pain. (Petitioner's Exhibit 1. See also R. at 127-28 (excessively large breasts often cause back pain, skeletal deformities, breathing difficulties, irritation and numbness; most women seek breast reduction for physical relief rather than for cosmetic improvement.))[5]

[5]The estimated cost of the procedure is only $2,600. (R. at 62, 71.)

SUMMARY OF THE ARGUMENT

Federal law requires state medicaid plans to have reasonable standards for determining the extent of medical assistance. A standard for determining eligibility is not reasonable when it may result in additional medical expense to repair damage which results from denying the treatment--e.g., back problems, neck problems, severe yeast infections. It is also unreasonable to deny such coverage when it denies coverage of a medically necessary procedure just because in most situations that procedure is merely cosmetic. Courts have made exceptions to allow coverage of unlisted medical procedures when excluding coverage is unreasonable and against the purpose and policies of Title XIX, and such an exception should be made in this case. D.H.C.F. should be required to allow A.M.L. to receive bilateral breast reduction mammoplasty because it is medically necessary.

ARGUMENT

A. Overview And Purposes Of The Medicaid Program

Medicaid is a joint federal-state program designed to meet some of the medical needs of low-income persons. 42 U.S.C. § 1396 (1988); Schweiker v. Hogan, 457 U.S. 569, 571 (1982). States are not required to participate in the Medicaid program;

however, once they choose to do so, they must comply with the Medicaid statute and implementing regulations. Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981). 42 U.S.C. § 1396d(a) (1988 & Supp. II 1990) sets forth the things that Medicaid provides coverage for.

A state participating in Medicaid must designate the state agency responsible for administering its program and must file a state plan with the federal agency stating, among other things, the coverage it intends to provide. 42 U.S.C. § 1396a(a)(5) (1988). The respondents in this case are the designated Utah Medicaid agency.

The purpose of Title XIX is "to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396 (1988).[6] Title XIX "was `designed to liberalize Federal law . . . so as to make medical services for the needy more generally available.'" Haley v. Commissioner of Public Welfare, 476 N.E.2d 572, 578 (Mass. 1985) (quoting S. Rep. No. 404, 89th Cong., 1st Sess. (1965) reprinted in 1965 U.S.C.C.A.N. 1943, 2014.) By denying benefits to A.M.L., the

[6]Utah Code Ann. § 26-18-2.1 (1989) and Utah Code Ann. § 26-18-3(2) (Supp. 1992) specifically incorporate Title XIX and other federal law and regulations into Utah's Medicaid program.

state Medicaid agency defeats the purpose of Title XIX as set forth in 42 U.S.C. § 1396, since the cost of her necessary medical services exceeded her income and resources.

The objective of the Medicaid act is to provide necessary medical services for all those unable to afford them and, while a state need not provide funding for all medical treatments and may determine the extent of medical services that it will provide, it may not employ that discretion to eliminate entirely from reimbursement medical services which have been certified by a qualified physician as being "medically necessary". Marsh v. Department of Public Welfare, 409 A.2d 926, 928-29 (Pa. Commw. Ct. 1979) (citing Roe v. Casey, 464 F.Supp. 487 (E.D. Pa. 1978)). The standard of medical necessity, as the standard for determining when medicaid assistance must be provided, is not explicit in the medicaid statute but has become judicially accepted as implicit to the legislative scheme and has been endorsed by the Supreme Court. Pinneke v. Preisser, 623 F.2d 546, 548 n.2, 549 n.3 (8th Cir. 1980) (citing Beal v. Doe, 432 U.S. 438, 444-45, 445 n.9 (1977)). It has also been endorsed by DHCF in its agency rules and regulations regarding policy recommendations. Utah Administrative Code § R414-26-1(f) (1993) (formerly R455-26-1(f)).

The "minimum necessary medical treatment", mandated by an eligible person's condition, must be provided by the Medicaid program and failure to do so is inconsistent with the scope and purpose of the Medicaid act. Marsh, 409 A.2d at 928-29. Breast reduction surgery is the minimum necessary medical treatment that will provide relief for A.M.L.'s pain and chronic neck and back problems and failure to provide this treatment is inconsistent with the scope and purpose of the Medicaid act. (See Petitioner's Exhibit 1; Respondent's Exhibit 2 at 8 (letter from Charles V. Pledger, M.D., July 1, 1991.))

In Pinneke, 623 F.2d at 549, the Eighth Circuit Court of Appeals found that Iowa's irrebuttable presumption that the procedure of sex reassignment surgery could never be medically necessary when the surgery is for treatment for transsexualism was not consistent with the objectives of the Medicaid statute. Similarly, Utah's presumption that breast reduction surgery is not medically necessary (see R. at 174, 198), is not consistent with the objectives of the Medicaid statute.

In Alexander L. v. Cuomo, the New York Supreme Court took the position that for Medicaid coverage "the medical care to be afforded is that which is `necessary' to effect a cure". 588 N.Y.S.2d 85 (N.Y. App. Div. 1991) (citing City of New York v. Wyman, 37 A.D.2d 700, 701 (N.Y. App. Div. 1971) (Steur, J.,

Dissenting) rev'd, 281 N.E.2d 670 (N.Y. 1972) (based on dissent.)) In the present case, breast reduction surgery is necessary to effect a cure for A.M.L.

B. It Is Unreasonable To Deny Coverage Of Treatment When Doing So May Result In Additional Medical Expense To Repair Damage Resulting From Denial Of That Treatment.

Federal law requires state medicaid plans to "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which are consistent with the objectives of this title." 42 U.S.C. § 1396a(a)(17) (Supp. II 1990). Although a state has considerable discretion in placing appropriate limitations on services rendered under a State medicaid plan, that discretion is limited by the federal regulations which require reasonableness. Biewald v. State, 451 A.2d 98, 100 (Me. 1982) (citing Beal, 432 U.S. at 444 and Simpson v. Wilson, 480 F.Supp. 97, 100 (D. Vt. 1979). To be reasonable in achieving their purpose, the amount, scope and duration of the treatment must be sufficient for most persons needing a particular type of care. Biewald, 451 A.2d at 100 (citing Virginia Hosp. Ass'n v. Kenley, 427 F. Supp. 781, 784-86 (E.D. Va. 1977). A standard for determining eligibility is not reasonable when it may result in additional medical expense to repair damage which results from denying the treatment--e.g.,

back problems, neck problems, severe yeast infections. (See Petitioner's Exhibit 1; Respondent's Exhibit 2 at 8 (letter from Charles V. Pledger, M.D., July 1, 1991.)) Reduction mammoplasty is a procedure listed as not being covered under Medicaid. (See Defendant's Exhibit 1 at 5 (Medicaid Information Bulletin, No. 90-41, Procedure Code #19318, June 20, 1990.)) Yet, procedures to correct conditions of the spine and neck are covered under Medicaid. See Medicaid Information Bulletin, No. 90-41, Procedure Code #22140 and #21899, June 20, 1990. Doctor Flinders said that A.M.L.'s large breast size has led to chronic neck and back problems, for which she seeks a reduction mammoplasty. (Petitioner's Exhibit 1.) It is unreasonable to deny the reduction mammoplasty, thereby causing neck and back problems which may result in a covered condition if they become sufficiently severe.

C. It Is Unreasonable To Deny Medicaid Coverage Just Because In Most Situations The Procedure Is For Cosmetic Purposes.

It is also unreasonable to deny such coverage when it denies coverage of a medically necessary procedure just because in most situations that procedure is merely cosmetic. A.M.L.'s treating physician said that, in his judgment, her motivation for reduction mammoplasty is not for cosmetic reasons, but for

medical reasons including relief of pain. (Petitioner's Exhibit 1.)[7] The opinion of A.M.L.'s treating physician carries more weight than that of the agency doctor who said that the reduction mammoplasty is not medically necessary. See Pinneke, 623 F.2d at 550; Dodson v. Parham, 427 F. Supp. 97, 109 (N.D. Ga. 1977); Jeneski v. Myers, 209 Cal. Rptr. 178, 187-88 (1984), cert. denied sub. nom. Kizer v. Jeneski, 471 U.S. 1136 (1985); Worthington v. State of Idaho Department of Health and Welfare, No. 69458, slip op. at 6-7 (2nd Dist. Idaho, Nez Perce County Feb. 20, 1992) (See Addendum.)[8]

In addition, recently a study was conducted regarding the medical necessity of reduction mammaplasty among the patients of 92 plastic surgeons. The study stated that a woman's motivation for breast reduction surgery is "purely medical" when she has a body surface area of 2.00 m2 and more than 628 grams of excess tissue in the breast. (Petitioner's Exhibit 13 at 7 (Paul L.

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[7]Pinneke, 623 F.2d at 550, provides that "[t]he decision of whether or not certain treatment or a particular type of surgery is `medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials." In this case, A.M.L.'s treating physician's opinion that the requested reduction mammoplasty is "medically necessary" should outweigh the conclusions to the contrary by D.H.C.F.'s personnel and officials.

[8]The federal courts have ruled that, in disability cases, more substantial weight is to be given to the opinion of the treating physician than to the opinion of other physicians. Frey v. Bowen, 816 F.2d 508 (10th Cir. 1987).

Schnur et al., Reduction Mammaplasty: Cosmetic or Reconstructive Procedure?, 27 Annals of Plastic Surgery 232 (1991.)) A.M.L. has a body surface area of 1.99 m2 (within 1/100th of the standard). (Petitioner's Exhibit 13 at 11 (letter from James M. Clayton, M.D., F.A.C.S.)) Yet, she has about 800 to 1,000 grams of excess breast tissue per side (greatly exceeding the amount given in the standard, yet distributed over less surface area). (Petitioner's Exhibit 2.) Therefore, her motivation for breast reduction surgery is "purely medical". (See also R. at 127-28 (The American Society of Plastic and Reconstructive Surgeons, Inc.) (excessively large breasts often cause back pain, skeletal deformities, breathing difficulties, irritation and numbness; most women seek breast reduction for physical relief rather than for cosmetic improvement.))

In Jeneski, 209 Cal. Rptr. 178, the court enjoined a requirement of prior authorization for certain drugs because doing so ignored the necessity that some patients have for drugs that might be "merely palliative" for others. See also Worthington, Case No. 69458 (Dist. Ct. 2nd Dist. Idaho) (although breast reconstruction was considered cosmetic and not a covered item, Idaho medicaid was required to cover this procedure for a woman, following a double mastectomy, because her treating physician testified that it was medically necessary). Similarly,

in this case, it is improper for reduction mammoplasty to be denied to A.M.L., on that basis that the treatment would be merely cosmetic in some people, when denying treatment ignores the necessity A.M.L. has for the treatment.[9]

D. Courts Have Made Exceptions To Allow Coverage Of Unlisted Medical Procedures In Other Cases.

Courts have made exceptions to allow coverage of unlisted medical procedures when excluding coverage is unreasonable or against the purpose and policies of Title XIX (such as when it is medically necessary). Jackson v. Stockdale, 264 Cal. Rptr. 525 (1989) (Medi-Cal's categorical exclusion of root canal treatment and laboratory processed crowns was unlawful); G.B. v. Lackner, 145 Cal. Rptr. 555 (1978) (Medi-Cal coverage required for radical

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[9]The DHCF physcian admitted that the motivation of women seeking breast reduction surgery may be based on the presence of intertrigo, grooves from the bra strap or back and/or shoulder pain and that there are other problems that women with significant "mammary hyperplasia" may experience that could be considered medical. (R. at 140-41, 144.) He concurred that these women often have a long-standing history of back and neck pain. (R. at 140-41.) He agreed that bachache and the grooves and dents in A.M.L.'s shoulders are symptoms of breast hypertrohpy. (R. at 153-54, 156.) He agreed that skin ulcerations result when there is a large damp and moist area underneath the breasts and that the size and weight of A.M.L.'s breasts are factors making it more difficult for infections and ulcerations underneath the breasts to heal properly. (R. at 142.) He admitted that a reduction mammoplasy would relieve the infections underneath the breasts and the dents in her shoulders. (R. at 148, 157.)

sex conversion surgery for treatment of transsexualism; such surgery was not cosmetic and was medically necessary); Doe v. Lackner, 145 Cal. Rptr. 570 (1978) (Medi-Cal coverage required for radical sex conversion surgery for treatment of transsexualism); Morgan v. Idaho Department of Health and Welfare, 813 P.2d 345 (Idaho 1991) (although treatment of obesity was generally excluded from coverage, Medicaid recipient was entitled to payment of medical expenses incurred in a weight loss program which was medically necessary to treat a condition known as pseudotumor cerebri and thereby to prevent blindness); Worthington, No. 69458 (2nd Dist. Idaho) (breast reconstruction surgery found medically necessary); Biewald, 451 A.2d at 100 (Medicaid coverage required for urine testing materials as medical supplies for a diabetic child); Doe v. State Department of Pub. Welfare, 257 N.W.2d 816 (Minn. 1977) (Minnesota medical assistance program was required to cover transsexual surgery, not otherwise payable under the medical assistance program, because it was medically necessary); Kirk v. Dunning, 370 N.W.2d 113 (Neb. 1985) (State of Nebraska prohibited from categorically refusing to provide periodontal treatment to a medicaid patient where such treatment was required); Alexander L., 588 N.Y.S.2d 85 (on Motion for Summary Judgment, the State of New York was ordered to provide coverage for the drug clozapine, dispite the

expense, as a "medical necessity" needed to cure schizophrenia); Marsh, 409 A.2d 926 (Pennsylvania Department of Public Welfare abused its discretion in excluding coverage of a test necessary to determine the correct dosage of Dilantin when the drug itself was covered and necessary to control seizures). Such an exception should be made in this case. In the present case D.H.C.F. found that a determination of medical necessity was also required (R. at 85-86) and Dr. Flinders determined that the reduction mammoplasty was medically necessary (See Petitioner's Exhibit 1 (letter from David C. Flinders, M.D.)) D.H.C.F. erred in finding that the reduction mammoplasty was not medically necessary (R. at 45, 196-205).[10]

E. Other Courts Have Required Coverage Of Breast Reduction On The Basis Of Medical Necessity.

As to the coverage of breast reduction surgery, a South Dakota circuit court reversed a final decision of the South Dakota Department of Social Services denying Medicaid coverage of a claimant's proposed reduction mammoplasty surgery. Bilby v. South Dakota Dept. of Social Services, No. 89-331 (S.D. 7th Cir. Ct., Pennington County Feb 8, 1989) (Petitioner's Exhibit 4; see

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[10]The DHCF physician was of the mistaken opinion that reduction mammoplasty would not be a covered benefit even if it was medically necessary. (R. at 171.)

Addendum). In its findings of fact the court held that reduction mammoplasy is not generally a cosmetic procedure and it was not proposed for cosmetic purposes in this case. (Petitioner's Exhibit 4 at 4). In Appeal of Serena B., No. 314-366117-5 (Ohio Department of Human Services Nov. 13, 1990) (Petitioner's Exhibit 3; see Addendum), an Ohio Department of Social Services hearing officer ordered that reduction mammoplasty be approved for coverage under the state's Medicaid program because it was medically necessary. Likewise, A.M.L.'s reduction mammoplasty is medically necessary and should be covered.

DHCF has promulgated a rule that cosmetic surgery would only be deemed "medically necessary" if it was to (1) correct a congenital anomaly, (2) restore body form or function after an accident, or (3) revise severe disfiguring and extensive scarring from neoplastic surgery. Utah Administrative Code § R414-10-6 (1993) (formerly R455-10-6). Such limitations on the definition of medical necessity are misguided and unsupported by the cases cited in the previous section, because A.M.L.'s treating physician, without referring to one of these categories, determined that the reduction mammoplasty was medically necessary. (See Petitioner's Exhibit 1.) Even if this restrictive definition of medical necessity was valid, it appears that A.M.L. would fall into the first category on the basis of

evidence that lupus is inherited and therefore a congenital anomaly. (Petitioner's Exhibit 7.)

F. It is Unlawful to Arbtrarily Deny a Service Simply Because of the Type of Illness.

A Medicaid agency "may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c) (1992).[11] In Simpson, 480 F. Supp. at 101 (D. Vt. 1979) the court ruled that Vermont's prohibition of Medicaid coverage for physician services for those suffering from refractive error of the eyes, while covering physician services for those suffering from eye diseases, constituted a violation of federal regulations and ordered Vermont Medicaid to cover these services; the court held that denying coverage for refractive error, though it may be as serious as an eye disease, was a reduction in the "scope of a required service . . . solely because of diagnosis, type of illness, or condition" contrary to 42 C.F.R. § 440.230(c). See also White v. Beal, 555 F.2d 1146 (3rd Cir. 1977) (Pennsylvania's

[11]Required services include "inpatient hospital services" (42 C.F.R. § 440.10) and "physician's services" (42 C.F.R. § 440.50). 42 C.F.R. § 440.230(c). Reduction mammoplasty falls into these medical assistance categories and must be covered by the state's Medicaid plan unless not medically necessary. See Pinneke, 623 F.2d at 550.

policy of providing eyeglasses to people who have pathology or disease of the eye, but not to those with refractive errors of the eyes, was struck down under the section then equivalent to 42 C.F.R. § 440.230(c) and also because it was a violation of the Equal Protection Clause); Weaver v. Reagen, 701 F. Supp. 717 (W.D. Mo. 1988), aff'd, but modified on other grounds, 886 F.2d 194 (8th Cir. 1989) (exception made to a Vermont Medicaid rule that limited Medicaid coverage of the drug AZT to only a particular group of AIDS patients); Pinneke, 623 F.2d at 549 (transsexual surgery was unlawfully denied because of the "diagnosis, type of illness or condition"; Doe, 257 N.W.2d at 820 (transsexual surgery was unlawfully denied because of the type of illness).

The service A.M.L. seeks is also being unlawfully denied because of her diagnosis of lupus. Medicaid will pay the cost of breast reconstruction surgery, a procedure performed on women suffering from breast cancer. Medicaid Information Bulletin, Procedure Code #19360, 19364. A.M.L.'s reduction mammoplasy is substantially similar to the breast reconstruction surgery for a cancer patient, in that it is to restore the breasts to a more normal state, following treatment of a severe illness--i.e., lupus. To deny a reduction mammoplasty to a lupus patient, while permitting a cancer patient to receive breast reconstruction

surgery is an arbitrary denial of the "amount, duration, or scope" rule, 42 C.F.R. § 440.230(c) (1992), and should not be approved by the court.

CONCLUSION

The court should reverse the decision of D.H.C.F. and find that A.M.L. is entitled to have her bilateral reduction mammoplasty covered by Medicaid.

Dated this 9th day of March, 1993.

Steven Elmo Averett
UTAH LEGAL SERVICES, INC.
By Steven Elmo Averett

ADDENDUM

[redacted]

☐ ATTACHMENT INDICATOR

FILE COPY

Form Number 24 08 37

REQUEST FOR PRIOR APPROVAL

UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

Prior Approval Document Number	No. 0209267

STATE USE ONLY	
6. Effective Date	
7. Termination Date	

1. Patient Name: Last, First, M.I.	2. Age	3. Sex	4. Client I.D. Number
Lastowski Ann Marie	25	F	c6004795 63

5. Patient Street Address, City, State, Zip Code
1165 E 580 S Provo, UT 84606

529-48-6300
528-27-2597

8. Proposed Medical Supplies, Drug, Therapy, or Surgical Procedures (Identify Primary Procedure First)	9. Procedure or CODE		10. Units	11. Estimated Cost	12. STATE USE ONLY Approved Amount	Units	Yes/No
1 Bilateral Breast Reduction	19318	50	130	2600 00			
2							
3							
4							
5							

13. Will the services of an: A. Anesthesiologist be used? ☑ Yes
B. Assistant at Surgery be used? ☑ Yes

14. Can this procedure be done in your office? ☐ Yes ☑ No (If no, complete items 15 through 18 below.)

15. Hospital Name and Address	16. STATE USE ONLY Hospital Provider Number	17. Estimated hospital days of stay	18. SURGICAL CODE	19. STATE USE ONLY Approved Length of Stay	Denied
Utah Valley Hospital 1034 N 500 W Provo, UT 84603		2	64721		

20. SUMMARY OF HISTORY: (Physical Examination, Laboratory, X-ray studies, prescriptions, and other applicable documentation must be supplied in sufficient detail to justify the necessity for the procedure. If the patient is mentally retarded or under psychiatric treatment, please so indicate and attach additional documentation as appropriate.)

Ann has Systemic Lupus erythematosus And has been on steroids for a Long time. She has problems with the back, Largely caused by Large breasts. She has pain in the upper back and in the neck, also constant pain in the shoulders & painful grooves from the bra straps. During the summer she gets severe yeast infections under the breasts.

On physical exam the patient has Large breasts that are very ptotic. She has about 800 to 1,000 grams of excess breast tissue per side.

21. If this request is for "Prior Authorization" for a Non-Therapeutic Sterilization Request, complete "A" through "C" below. Also attach the completed copy No. 1 of Form 499-A (Part II), before mailing to this office.

A. Is the above patient in an institution or a correctional facility? ☐ Yes ☐ No.

B. Is the above patient mentally ill? ☐ Yes ☐ No.

C. Is the above patient mentally retarded? ☐ Yes ☐ No.

Patient's Date of Birth: ____ MM DD YY

22. Name and Address of Requesting or Supplying Provider
CHARLES V. PLEDGER, M.D., P.C.
3311 No. University Ave., Suite 100
Provo, Utah 84604

23. Signature

24. Requesting Provider Number
529-66-0115-019

25. Name and Address of Referring or Prescribing Provider
[redacted]

MAR 1 1991

26. Referring or Prescribing Provider License Number

NOTE: This is NOT a certificate of eligibility nor a guarantee of payment amount requested. Eligibility must be confirmed by reviewing an eligibility card current for the month services are to be performed.

FOR STATE USE ONLY

27. Reviewer I.D. ☐☐☐

28. Signature of Reviewing Authority

M M D D Y Y
Approval Date

DH DHCF PA-3 (3-82)

DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

Norman H. Bangerter
Governor
Suzanne Dandoy, M.D., M.P.H.
Executive Director
Rod Betit
Director

288 North 1460 West
P O Box 16580
Salt Lake City, Utah 84116-0580
(801) 538-6151

ANN MARIE LASTOWSKI, Petitioner, v. UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING, Respondent.	)	INTERIM AGENCY ACTION AND REMAND Case No. 91-156-02

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6151.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R454-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients and Providers."

ISSUE

WAS THE RESPONDENT CORRECT IN DENYING PRIOR AUTHORIZATION FOR A REDUCTION MAMMOPLASTY?

DISPOSITION

WHEREFORE, upon review of the record as a whole, Recommended Decision No. 91-156-02 is hereby REMANDED to the presiding officer to obtain recommendations from a Division of Health Care Financing physician consultant regarding the medical necessity of the requested service. The petitioner shall be allowed to examine those recommendations and present additional evidence.

REASONS FOR THE DISPOSITION

Medical expertise is needed to determine whether or not an exception to the current policy regarding reduction mammoplasties should be made in this case.

RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Interim Agency Action and Remand is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action and Order on Review or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Action and Order on Review.

A copy of this Final Agency Action and Order on Review shall be sent to Petitioner or her representative at the last known address by certified mail, return receipt requested.

DATED this 18th day of November 1991

UTAH DEPARTMENT OF HEALTH
Suzanne Dandoy, Executive Director

BY: Rod Betit
Rod Betit, Director
Division of Health Care Financing
Her Designated and Authorized Representative

0458H/78-79

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

----------oo0oo----------

ANN MARIE LASTOWSKI, Petitioner, vs. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	**RECOMMENDED DECISION** Case No. 91-156-02

Pursuant to Rule R454-14 of the Utah Department of Health and the Utah Administrative Procedures Act, Section 63-46b-1 et seq., Utah Code Annotated, 1953 as amended, a formal administrative hearing for the above captioned case was held on the 9th day of August, 1991, at the Office of Family Support located at 150 East Center Street, Provo, Utah, at 9:30 a.m., Cornelius W. Hyzer, Hearing Officer, presiding. The petitioner appeared in person was represented by Utah Legal Services, Inc., Steven Averett, Attorney at Law, and Gary Gibb, Law Clerk. Also appearing on behalf of the petitioner were Carol Lastowski and Laura Mitchell.

The respondent was not represented.

ISSUE

IS THE POLICY OF THE RESPONDENT THAT REDUCTION MAMMOPLASTY IS NOT WITHIN THE SCOPE OF SERVICE OF MEDICAID REASONABLE UNDER THE CIRCUMSTANCES PRESENTED BY THE PETITIONER HEREIN?

The petitioner, Ann Lastowski, age 27, has a confirmed diagnosis of Lupus Erythematosus. She first developed symptoms of this disease when she was about 17 years old. Since that time, she has been prescribed anti-inflammatories, including specifically the drug Prednisone. This drug helps control the disease's symptoms, even though the disease itself has no cure at this time. The primary side-effects from taking Cortisone type products has been an increase in her appetite, weight gain to more than 190 pounds, and massive breast enlargement. The petitioner is presently

receiving SSI benefits and is on Medicaid. She presently experiences great discomfort due the size of her breasts and requested that her doctor surgically correct the problem through a reduction mammoplasty.

Medicaid prior approval was denied because it is deemed a cosmetic or non-covered service.

FINDINGS OF FACT

1. The petitioner, Ann Marie Lastowski, age 27, is diagnosed as having Lupus Erythematosus since she was 17 years old.

2. The petitioner has been prescribed Prednisone for the control of her disease but has suffered the side-effects of increased appetite, fluid retention, weight gain to in excess of 190 pounds, and enlarged breasts.

3. The difficulties which the petitioner presently suffers from as a direct result of her enlarged breasts include: difficulty breathing, discomfort at night such that she cannot sleep, shoulder pain due to the weight on her bra straps, non-healing ulcerations under her breasts due to yeast infections particularly in the summer months.

4. The petitioner also has chronic neck and back problems due to the excess weight, which includes pain and aggravation of her primary diagnosis.

5. The opinion of the petitioner's primary physician is that the operation is not cosmetic but for relief from pain, as set forth in Petitioner's Exhibit #1. The opinion is supported by that of the plastic surgeon, as set forth in Petitioner's Exhibit #2.

6. Reduction mammoplasty is a non-covered service of the Utah Medicaid program as set forth in Respondent's Exhibit #1.

CONCLUSIONS OF LAW

Because reduction mammoplasty is a non-covered service by definition with the Utah Medicaid program, the petitioner's request for prior authorization must be denied.

REASONS FOR HEARING OFFICER'S DECISION

The petitioner presented a very convincing case for the

creation of an exception to the non-service rule, however no such exception is permitted under the rules. The pertinent section of the rule as set forth in Respondent's Exhibit #1 states:

M. Cosmetic, Plastic, or Reconstructive Services

1. Cosmetic, plastic, or reconstructive surgery procedures may only be covered when medically necessary to:

a. correct a congenital anomaly;

b. restore body form or function following an accidental injury; or

c. revise severe disfiguring and extensive scarring resulting from neoplastic surgery.

These exceptions provide the only basis for prior approval by Medicaid. The Medicaid Prior Authorization Unit provides a list of non-covered services to the provider physicians, and page 3 (included in Respondent's Exhibit #1) includes "19318 Reduction mammoplasty".

RECOMMENDED AGENCY ACTION

The decision of the respondent to deny the petitioner's request for a reduction mammoplasty is hereby AFFIRMED.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represents the results of that review, will be released simultaneously by the Department of Health Care Financing.

DATED this 11th day of October, 1991.

Cornelius W. Hyzer

CORNELIUS W. HYZER
HEARING OFFICER

EXHIBITS

The following exhibits were admitted into evidence:

PETITIONER'S EXHIBIT #1:	Letter dated August 5, 1991, from Dr. Flinders
PETITIONER'S EXHIBIT #2:	Letter dated March 5, 1990, from Dr. Pledger
PETITIONER'S EXHIBIT #3:	Ohio Hearing result
PETITIONER'S EXHIBIT #4:	South Dakota hearing result
PETITIONER'S EXHIBIT #5:	Insurance Form from Industrial Commission
PETITIONER'S EXHIBIT #6:	Article from "Today's Quest", Vol. 7, #4
PETITIONER'S EXHIBIT #7:	Lupus pamphlet
PETITIONER'S EXHIBIT #8:	Hearing Brief
PETITIONER'S EXHIBIT #9:	Medical records
PETITIONER'S EXHIBIT #10:	Photographs
PETITIONER'S EXHIBIT #11:	Cases from other courts
RESPONDENT'S EXHIBIT #1:	Copies of policy information, rules and a coverletter dated 8/8/91

CERTIFICATE OF MAILING

I hereby certify that on the 18th day of November, 1991, I mailed a true and correct copy of the foregoing Final Agency Action and Order on Review, postage prepaid, to the following parties:

Steven Elmo Averett
Utah Legal Services, Inc.
455 North University Avenue, Suite 100
Provo, Utah 84601

Ann Marie Lastowski
1165 E. 580 S.
Provo, Utah 84601

Urla Jeane Maxfield
Coverage and Reimbursement
INTER OFFICE MAIL

Lois Combs
Managed Health Care
INTER OFFICE MAIL

Gary Gibbs
Utah Legal Services, Inc.
455 North University Avenue, Suite 100
Provo, UT 84601

J. Stephen Mikita
Office of the Attorney General
236 State Capitol
INTER OFFICE MAIL

Rod Betit, Director
Division of Health Care Financing
288 North 1460 West
Salt Lake City, UT 84116

Dominique Gallegos

0379H/29/ddg

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

----------oo0oo----------

ANN MARIE LASTOWSKI, Petitioner, vs. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	**ORDER ON OBJECTION** Case No. 91-156-02

The court having received the OBJECTION TO DR. HYLEN'S MEMO AND AFFIDAVIT OF ANN MARIE LASTOWSKI within the time period allowed by the court's letter dated February 10, 1992, and the court being fully advised in the premises, hereby enters the following:

ORDER

1. The objection of the petitioner that the Memo of Dr. Hylen be not admitted into evidence is hereby overruled, and Dr. Hylen's Memo dated February 4, 1992, is hereby admitted into evidence as Respondent's Exhibit #2.

2. The petitioner's OBJECTION TO DR. HYLEN'S MEMO AND AFFIDAVIT OF ANN MARIE LASTOWSKI is hereby admitted into evidence as Petitioner's Exhibit #12.

3. The petitioner is granted 10 days to request a hearing in writing that the respondent shall make available Dr. Hylen as a expert witness, subject to cross-examination. If no request is received within 10 days, then the court shall enter its recommended decision based upon the evidence in the record.

REASONS FOR HEARING OFFICER'S ORDER

The Utah Code provides in Section 63-46b-8(1)(c) that "the presiding officer may not exclude evidence solely because it is hearsay." Dr. Hylen's Memo dated February 4, 1992, is clearly hearsay, but that was not the basis of the objection of the petitioner. The petitioner's objection was because "the information contained therein is either incorrect or out-dated." (Petitioner's Exhibit #12, page 1.) This argument goes to the weight to be given to the evidence, but not against its admissibility.

Section 63-46B(1)(d) provides that "the presiding officer shall afford to all parties the opportunity to present evidence, argue, respond, conduct cross-examination, and submit rebuttal evidence." The evidence submitted by the petitioner in her objection constitutes rebuttal evidence. Therefore, it should be admitted and ascribed the appropriate weight in countering the evidence submitted by the respondent in Dr. Hylen's Memo.

DATED this 20th day of February, 1992.

Cornelius W. Hyzer

CORNELIUS W. HYZER
HEARING OFFICER

EXHIBITS

The following exhibits were admitted into evidence:

PETITIONER'S EXHIBIT #1:	Objection to Dr. Hylen's Memo and Affidavit;
RESPONDENT'S EXHIBIT #2:	Dr. Hylen's Memo dated 2/4/92.

CERTIFICATE OF MAILING

I, the undersigned, hereby certify that a true and correct copy of the foregoing ORDER ON OBJECTION was mailed by U.S. Mail, postage prepaid, together with a copy of Petitioner's Exhibit #12 and Respondent's Exhibit #2, on the 21st day of February, 1992, to the following:

Steven Elmo Averett
Utah Legal Services
455 North University Avenue. Suite 100
Provo, Utah 84601

Ann Marie Lastowski
1165 East 580 South
Provo, Utah 84601

Urla Jeane Maxfield
Coverage and Reimbursement
INTER OFFICE MAIL

Lois Combs
Managed Health Care
INTER OFFICE MAIL

Dr. John C. Hylen
Managed Health Care
INTER OFFICE MAIL
Gary Gibbs
Utah Legal Services
455 North University Avenue, Suite 100
Provo, Utah 84601

J. Stephen Mikita
Office of the Attorney General
236 State Capitol
INTER OFFICE MAIL

Rod Betit, Director
Division of Health Care Financing
288 North 1460 West
Salt Lake City, Utah 84116

Dominique Gallegos

Norman H. Bangerter
Governor
zanne Dandoy, M.D., M.P.H.
Executive Director
Rod Betit
Director

State of Utah
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

288 North 1460 West
P O Box 16580
Salt Lake City Utah 84116-0580
(801) 538-6151

ANN MARIE LASTOWSKI,
Petitioner,
vs.

UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING,
Respondent.

FINAL AGENCY ACTION
Case No. 91-156-02

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6151.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R410-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

ISSUE

IS THE RESPONDENT'S POLICY REGARDING REDUCTION MAMMAPLASTIES REASONABLE UNDER THE CIRCUMSTANCES PRESENTED BY THE PETITIONER IN THIS CASE?

FINDINGS OF FACT

The Findings of Fact entered by the presiding officer in Recommended Decision No. 91-156-02 are hereby incorporated by reference.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the presiding officer in Recommended Decision No. 91-156-02 are hereby incorporated by reference.

DISPOSITION

WHEREFORE, upon review of the record as a whole, Recommended Decision No. 91-168-02 is hereby AFFIRMED.

REASONS FOR THE DISPOSITION

Department of Health Administrative Rule R414-4-7 (formerly numbered R455-4-7) states in part:

> A. Procedures and services determined to be cosmetic, experimental, or of unproven medical value are non-covered services. Criteria established and approved by the Division of Health Care Financing staff and physician consultants are used by the Division of Health Care Financing staff and medical consultants to determine non-covered status of services and procedures. Non-covered services are listed in the Medical and Surgical Procedures Prior Authorization List and maintained in the Outpatient Hospital Provider Manual. The list is not exclusive, other limitations may be documented in specific programs or by specific policy.
>
> 1. Cosmetic, reconstructive, or plastic surgery is considered medically necessary and limited to being provided only in the following circumstances:
>
> a. correction of a congenital anomaly; or
> b. restoration of body form following an accidental injury; or
> c. revision of severe disfiguring and extensive scars resulting from neoplastic surgery [emphasis added].

The case was remanded to the presiding officer to obtain medical expertise to determine whether an exception to the current rule regarding cosmetic, reconstructive, or plastic surgery, such as reduction mammaplasty, should be made in the petitioner's case based upon medical necessity.

The petitioner was allowed the opportunity to present additional evidence, and cross examine the respondent's expert witness when the hearing was reconvened.

The position of the respondent's expert witness was that the requested reduction mammaplasty was not medically necessary, because the procedure is of unproven value [see R414-4-7, above]. He testified that the fact that the petitioner has lupus and is taking Prednisone greatly enhances her likelihood of having infections under her breasts, and that those infections would be likely to continue even if she were to have a reduction mammaplasty. He further testified that he was uncertain as to whether a breast reduction is ever medically necessary, but it is clearly not medically necessary in this case.

Since the petitioner did not prove by the preponderance of the evidence that a reduction mammaplasty is medically necessary in light of her overall medical condition and the hearing record as a whole, the respondent was correct in its determination that the procedure is not medically necessary.

RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Final Agency Action is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Action.

A copy of this Final Agency Action shall be sent to Petitioner or representative at the last known address by certified mail, return receipt requested.

DATED this 10th day of August 1992

Rod Betit

Rod Betit, Director
Interim Executive Director
UTAH DEPARTMENT OF HEALTH

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

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ANN MARIE LASTOWSKI, Petitioner, vs. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	RECOMMENDED DECISION ON REMAND Case No. 91-156-02

Pursuant to Rule R454-10 of the Utah Department of Health and the Utah Administrative Procedures Act, Section 63-46b-1 et seq., Utah Code Annotated, 1953 as amended, a formal administrative hearing on remand for the above captioned case was held on the 21st day of July, 1992, at the office of Utah Legal Services, Inc., located at 455 North University, Suite 100, Provo, Utah, at 1:00 P.M., Cornelius W. Hyzer, Hearing Officer, presiding. The petitioner appeared in person was represented by Utah Legal Services, Inc., Steven Averett, Attorney at Law, and Gary Gibb, Law Clerk. Also appearing on behalf of the petitioner was Carol Lastowski.

The respondent was represented by Doug Springmeier, Assistant Attorney General, and John C. Hylen, M.D., Joan Gallegoes, Urla Jeane Maxfield, and Bonnie Holmes, by telephone conference call to the Cannon Health Building, Room 321, in Salt Lake City, Utah.

ISSUE

IS THE POLICY OF THE RESPONDENT THAT REDUCTION MAMMOPLASTY IS NOT WITHIN THE SCOPE OF SERVICE OF MEDICAID REASONABLE UNDER THE CIRCUMSTANCES PRESENTED BY THE PETITIONER HEREIN?

The petitioner, Ann Lastowski, age 27, has a confirmed diagnosis of lupus erythematosus. She first developed symptoms of this disease when she was about 17 years old. Since that time, she has been prescribed anti-inflammatories, including specifically the drug Prednisone. This drug helps control the disease's symptoms, even though the disease itself has no cure at this time. The primary side effects

from taking Cortisone type products has been an increase in her appetite, weight gain to more than 190 pounds, and massive breast enlargement. The petitioner is presently receiving SSI benefits and is on Medicaid. She presently experiences great discomfort due the size of her breasts and requested that her doctor surgically correct the problem through a reduction mammoplasty.

Medicaid prior approval was denied because it is deemed a cosmetic or non-covered service.

FINDINGS OF FACT

1. The petitioner, Ann Marie Lastowski, age 27, is diagnosed as having lupus erythematosus since she was 17 years old.

2. The petitioner has been prescribed Prednisone for the control of her disease but has suffered the side-effects of increased appetite, fluid retention, weight gain to in excess of 190 pounds, and enlarged breasts.

3. The difficulties which the petitioner presently suffers from as a direct result of her enlarged breasts include: difficulty breathing, discomfort at night such that she cannot sleep, shoulder pain due to the weight on her bra straps, non-healing ulcerations under her breasts due to yeast infections particularly in the summer months.

4. The petitioner also has chronic neck and back problems due to the excess weight, which includes pain and aggravation of her primary diagnosis.

5. The opinion of the petitioner's primary physician is that the operation is not cosmetic but for relief from pain, as set forth in Petitioner's Exhibit #1. The opinion is supported by that of the plastic surgeon, as set forth in Petitioner's Exhibit #2.

6. Reduction mammoplasty is a non-covered service of the Utah Medicaid program as set forth in Respondent's Exhibit #1.

7. The expert witness for the respondent, John C. Hylen, M.D., testified that the reduction operation would not eliminate or even reduce the symptoms which the petitioner complained of because the pain and other problems were caused more directly by her underlying disease, as set forth in Respondent's Exhibit #2.

8. The petitioner has not suffered from any infections underneath her breasts this summer but still shows evidence of scars from infections she had the previous summer, as set forth in Petitioner's Exhibit #13, last page, letter from Dr. Clayton dated July 15, 1992.

CONCLUSIONS OF LAW

1. Because reduction mammoplasty is a non-covered service by definition with the Utah Medicaid program, the petitioner's request for prior authorization must be denied.

2. The Interim Agency Action and Remand dated November 18, 1991, states, "Medical expertise is needed to determine whether or not an exception to the current policy regarding reduction mammoplasties should be made in this case." The testimony of the medical expert concluded that no such exception should be made.

REASONS FOR HEARING OFFICER'S DECISION

The petitioner presented a very convincing case for the creation of an exception to the non-service rule, however no such exception is permitted under the rules. The pertinent section of the rule as set forth in Respondent's Exhibit #1 states:

> M. Cosmetic, Plastic, or Reconstructive Services
>
> 1. Cosmetic, plastic, or reconstructive surgery procedures may only be covered when medically necessary to:
>
> a. correct a congenital anomaly;
>
> b. restore body form or function following an accidental injury; or
>
> c. revise severe disfiguring and extensive scarring resulting from neoplastic surgery.

These exceptions provide the only basis for prior approval by Medicaid. The Medicaid Prior Authorization Unit provides a list of non-covered services to the provider physicians, and page 3 (included in Respondent's Exhibit #1) includes "19318 Reduction mammoplasty".

The testimony of the expert witness for the respondent confirmed Respondent's Exhibit #2, the opinion submitted in written form. The purpose of the continued hearing held on July 21, 1992, was to allow the petitioner the opportunity to cross-examine the respondent's expert witness. The testimony of the expert centered on the fact that underlying symptoms of lupus and the drug therapy were more likely the source of her pain and related symptoms than the size of her breasts. This testimony was not controverted by the written exhibits submitted by the petitioner. None of those exhibits discussed the enlargement of the breasts in the context of lupus and steroid drug use. Only the respondent's expert witness testimony included a full view of the petitioner's overall medical condition. Dr. Clayton's letter dated July 15, 1992, does not even mention her lupus or extensive steroid drug therapy. He only mentions her large breasts and the symptoms, some of which are not present this summer.

The petitioner was concerned that the report by Dr. Clayton mentioned lumbar disc disease but in an ex parte communication while off the record on July 21, 1992, stated that a very recent MRI revealed no lumbar disc disease which may have been a contributing factor in her back pain. However, Dr. Clayton's letter is still deficient because it does not address any of the serious underlying disease processes which will continue to cause the petitioner pain and other difficulties, as testified to by the respondent's expert witness. The ex parte communication was not considered relevant by the hearing officer and therefore was not a factor in making this decision.

The hearing officer is not usually expected to offer a recommended change or exception to policy. The remand order requested that the testimony of a medical expert be placed in the record. That testimony was positively against the creation of an exception in this case.

RECOMMENDED AGENCY ACTION

The decision of the respondent to deny the petitioner's request for a reduction mammoplasty is hereby AFFIRMED.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represents the results of that review, will be released simultaneously by the Department of Health Care Financing.

DATED this 29th day of July, 1992.

CORNELIUS W. HYZER
HEARING OFFICER

EXHIBITS

The following exhibits were admitted into evidence:

PETITIONER'S EXHIBIT #1:	Letter dated August 5, 1991, from Dr. Flinders;
PETITIONER'S EXHIBIT #2:	Letter dated March 5, 1990, from Dr. Pledger;
PETITIONER'S EXHIBIT #3:	Ohio Hearing result;
PETITIONER'S EXHIBIT #4:	South Dakota hearing result;
PETITIONER'S EXHIBIT #5:	Insurance Form from Industrial Commission;
PETITIONER'S EXHIBIT #6:	Article from "Today's Quest", Vol. 7, #4;
PETITIONER'S EXHIBIT #7:	Lupus pamphlet;
PETITIONER'S EXHIBIT #8:	Hearing Brief;
PETITIONER'S EXHIBIT #9:	Medical records;
PETITIONER'S EXHIBIT #10:	Photographs;
PETITIONER'S EXHIBIT #11:	Cases from other courts;
PETITIONER'S EXHIBIT #12:	Objection to Dr. Hylen's Memo and Affidavit of Ann Marie Lastowski;
PETITIONER'S EXHIBIT #131:	Medical Articles and letter from Dr. Clayton dated July 15, 1992;
RESPONDENT'S EXHIBIT #1:	Copies of policy information, rules and a cover letter dated 8/8/91;
RESPONDENT'S EXHIBIT #2:	Memo of Dr. Hylen dated February 4, 1992.

CASE SUMMARY reduction surgery

Subject: Health
Level 1: Medicaid
Level 2: Prior Authorization

File No: HE-101
Month Published: April/May 1991

Appeal of Serena B.
Case No. 314-366117-5

Forum: Ohio Department of Human Services - State Hearing

Advocate/Source: Pauletta Hansel, Legal Aid Society of Cincinnati

Law: Ohio Medicaid Provider Handbook (OMPH) Chapter 3336

Issue: Whether the denial of the Bureau of Medical Operations (BMO) of prior authorization for breast reduction surgery because it was not established to be medically necessary was correct.

Facts: Ms. B. decided to seek medical attention in July 1990 because she had suffered from back, breast and neck pains for over a year. Ms. B. is 21 years old, is 5' 3" tall, and weighs 135 lbs. She wears a bra size of 44DD. Ms. B. has raw grooves in her shoulders from the weight of her breasts pulling on the shoulder straps of her bra. Her family doctor suggested breast reduction surgery and referred her to a plastic surgeon. Her breasts have always been large, but after bearing a child, they became progressively larger. Ms. B. cannot run, cannot sit up straight, and has difficulty exercising because of the pain it causes.

Ms. B.'s doctor sent the papers for prior authorization. After about eight weeks, she had not heard anything. After calling the BMO five times, she was finally informed that her case was denied because there was not enough medical evidence to support her case. Ms. B. requested a state hearing. She then obtained a second opinion. The second doctor also said that it was a medical necessity that she have the surgery as her problems would probably get worse.

At the hearing, the BMO representative testified that the standard for establishing medical necessity is whether the procedures are necessary to sustain life. Medical necessity is determined by objective signs which indicate that retention of the large breasts is going to cause significant damage, or cause morbidity or mortality. This has not been proven. The representative also stated that this person does have large breasts, and she is very much overweight. He stated that Ms. B. was in need of weight reduction more than surgical removal of breast tissue.

Ms. B. argued that she is not morbidly obese, but is definitely overweight. Additionally, Ms. B. has been on a weight reduction diet since August 1990, and has lost some weight, although the weight loss has not resulted in any loss of breast size. Ms. B.'s representative submitted an insurance weight chart, which shows that Ms. B. is only a few pounds outside the limit for maximum longevity. All of Ms. B.'s doctors have stated that the reduction is medically indicated and would reduce her symptoms.

Decision/Summary: The hearing officer ordered that the reduction surgery be approved because it is essential for Ms. B.'s well-being.

The OMPH does not state that only services necessary to prolong life are considered medically necessary. That concept is the subjective interpretation of the BMO. Ms. B.'s condition causes her continuous pain. As a result of her condition, Ms. B.'s lifestyle is limited, and, considering the action of aging and gravity on the human body, the situation can only worsen. The hearing officer found that the breast reduction surgery was a medical necessity.

Decision Date: November 13, 1990

Documents Available from OSLSA: State Hearing Decision

STATE OF SOUTH DAKOTA)
) SS
COUNTY OF PENNINGTON)

IN CIRCUIT COURT

SEVENTH JUDICIAL CIRCUIT

MELISSA BILBY,

Appellant,

vs.

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES,

Appellee.

Case No. 89-331

JUDGMENT

This matter having come before the Court upon Appellant's appeal from an adverse agency decision, the Court having reviewed the record in the matter, including the transcript of the administrative hearing, the hearing decision, the exhibits offered at the hearing, the briefs submitted by the parties, and the oral argument of the parties, the Court being fully advised in the premises, and for good cause shown, it is hereby

ORDERED, ADJUDGED, AND DECREED that the final decision, dated September 1, 1988, of Appellee, South Dakota Department of Social Services, denying Appellant appeal from an agency ruling that refused to provide Medicaid coverage for Appellant's proposed reduction mammoplasty, is hereby reversed, and it is further

ORDERED, ADJUDGED, AND DECREED that the matter is remanded to Appellee, South Dakota Department of Social Services, with instructions to the South Dakota Department of Social Services to provide full and complete Medicaid coverage and

reimbursement for Appellant's needed reduction mammoplasty, forthwith; and it is further

ORDERED, ADJUDGED, AND DECREED that Appellee, South Dakota Department of Social Services, shall pay to Appellant statutory costs in this matter pursuant to SDCL § 15-17-1; the amount of such costs having been set by statute at $25.00 for an action without trial (SDCL § 15-17-2(1)) and at $27.00 for copying costs of Appellant's Brief and Reply Brief (60 pages x $.15 per page x 3 copies = $27.00)(SDCL § 15-17-4) and $6.00 for service of process fees ($2.00 certified mail costs for service of 3 copies of the Notice of Appeal); for a total award of costs of $58.00.

Dated this 8 day of Feb, 1989.

BY THE COURT:

Honorable Marshall Young
Circuit Court Judge

ATTEST:

Frank E. Condon
Clerk of Courts

By: Pam Liston
Deputy Clerk

(SEAL)

Pennington County, S.D.
FILED
IN THE CIRCUIT COURT
9:30 A.M.
FEB 8 1989
Frank E. Condon, Clerk
By Deputy

STATE OF SOUTH DAKOTA)		IN CIRCUIT COURT
) SS		
COUNTY OF PENNINGTON)		SEVENTH JUDICIAL CIRCUIT
MELISSA BILBY,	)	Case No. 89-331
Appellant,	)	
	)	FINDINGS OF FACT
vs.	)	AND
	)	CONCLUSIONS OF LAW
SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES,	)	
Appellee.	)	

This matter having come before the Court upon Appellant's appeal from an adverse decision by Appellee, South Dakota Department of Social Services, the Court having reviewed the administrative record, including the transcript of the administrative hearing, the exhibits offered at the hearing, and all briefs submitted by the parties, the Court having heard oral argument from the parties, the Court being fully advised in the premises, and for good cause shown, the Court hereby makes the following:

FINDINGS OF FACT

I.

Appellant has appealed from an adverse final decision of the Department of Social Services denying her coverage for reduction mammoplasty surgery.

II.

Reduction mammoplasty surgery is necessary, according to Appellant's physicians, to treat Appellant's illness which includes backache, shoulder pains, bra strap grooving, and intermittent skin breakdown, and migraine headaches.

III.

Appellant's physicians have testified and established that reduction mammoplasty is medically necessary for Appellant to relieve the aforementioned symptoms.

IV.

The reduction mammoplasty is not a cosmetic procedure generally, nor is it proposed for cosmetic purposes in the Appellant's case.

V.

Appellee erred in concluding that Appellant failed to present evidence showing proposed reduction mammoplasty was necessary in her case.

VI.

Appellee erred in failing to adopt the Hearing Examiner's proposed decision as a final decision.

VII.

The proposed decision by the Hearing Examiner was proper and correct and should be adopted in this case.

VIII.

Although Appellant has pointed out that Appellee failed to decide this case within the federally mandated time limits, the Court need not decide the case on that basis, since the evidence clearly support the medical necessity of the proposed surgery for Appellant.

IX.

Although Appellant has raised serious questions concerning the propriety of Appellee's alleged mixture of prosecutorial and judicial functions, and allegations of the appearance of bias and partiality, the Court need not decide the case on that basis, since the evidence establishes that Appellant's proposed surgery is medically necessary.

X.

The Court is left with a firm and definite conviction that a mistake was made by Appellee in issuing its final decision against Appellant.

CONCLUSIONS OF LAW

I.

This Court has jurisdiction over the parties and the subject matter of this appeal.

II.

Because the physicians have indicated that Appellant's proposed reduction mammoplasty surgery is medically necessary, Appellant is entitled to Medicaid coverage for such surgery.

III.

Appellee erred in denying coverage for reduction mammoplasty for Appellant.

IV.

Appellee's decision denying coverage was erroneous as a matter of law and the rights of Appellant were prejudiced as a result of the erroneous decision of Appellee.

V.

The proposed reduction mammoplasty for Appellant is not, as a matter of law, cosmetic surgery within the meaning of South Dakota regulations concerning cosmetic surgery.

VI.

The proposed reduction mammoplasty for Appellant is medically necessary and thus fully covered by Medicaid.

VII.

This matter is reversed and remanded with instructions to Appellee to reinstate the Hearing Examiner's decision, and provide Medicaid coverage for Appellant for reduction mammoplasty forthwith.

Let judgment be entered accordingly.

Dated this 8 day of Feb, 1989.

BY THE COURT:

Honorable Marshall Young
Circuit Court Judge

ATTEST:

By Frank E. Condon
Clerk of Courts

By: Pam Puston
Deputy Clerk

(SEAL)

Pennington County, S.D.
FILED
IN THE CIRCUIT COURT

FEB 7 1989

Frank E. Condon, Clerk

IN THE DISTRICT COURT OF THE SECOND JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF NEZ PERCE

KELLY WORTHINGTON,	)	
	)	
Appellant,	)	CASE NO. 69458
	)	
v.	)	MEMORANDUM DECISION
	)	AND ORDER
STATE OF IDAHO DEPARTMENT OF HEALTH AND WELFARE,	)	
	)	
Respondent.	)	

Appellant has petitioned this Court for review of the decision issued by the designated hearing officer for the Respondent upholding the Department's denial of Medicaid coverage for breast reconstruction following a double mastectomy. Oral argument was heard by the Court on November 14, 1991, from Randall Robinson, attorney for Appellant, and from Edward C. Lockwood, attorney for Respondent.

In this Court's review of agency proceedings, it sits in an appellate capacity. The standard of judicial review is contained in section 67-5215(g), Idaho Code (Supp. 1991):

(g) The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. . . .The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) in violation of constitutional or statutory provisions;
(2) in excess of the statutory authority of the agency;
(3) made upon unlawful procedure;
(4) affected by other error of law;
(5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
(6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

The purpose of Medicaid is to enable the states to furnish medical assistance to families with dependent children, the aged, and the disabled, who have insufficient income to meet their medical needs. 42 U.S.C. 1396. It is a scheme of cooperative federalism, in which the states are obligated to comply with the federal Medicaid statute and regulations promulgated thereunder. Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981).

Appellant essentially argues that breast reconstruction in this case constituted a noncosmetic, medically necessary treatment for her condition. Respondent contends that the reconstruction was purely cosmetic in nature, and medically unnecessary under its general, unwritten definitions of "cosmetic surgery" and "medical necessity." The designated hearing officer concluded as follows:

> Although the Petitioner's circumstances are compelling, the Department's arguments in support of its decision to pay for the Petitioner's mastectomy, but not for her breast reconstruction are more persuasive than the Petitioner's contrary arguments, based upon the facts presented in this case. It is somewhat inconvenient that

> the Department has neither defined cosmetic surgery nor medical necessity in its regulations. It is however, appropriate to apply the plain meaning of those terms in deciding this case as there are no set applicable definitions.
>
> * * *
>
> [T]he Department is not required to accept every conclusion of a treating physician. The Department is free to evaluate the basis for the conclusion, and to reject inaccurate or unsupported conclusions.
>
> * * *
>
> The Department was within its power to consider breast reconstruction following a medically necessary mastectomy as a cosmetic procedure which is not covered under the Idaho Medicaid program, both generally and under the facts of this case.

Worthington v. State of Idaho Department of Health and Welfare, Appeal No. 89-119-2-14, at 9, 12, 14 (April 3, 1991)(findings of fact, conclusions of law, decision). For the reasons that follow, the Court reverses the decision of the hearing officer.

IDAPA 16.03.9065, entitled "Services Not Covered by Medical Assistance," is the Department's basis for refusal to pay for the Appellant's breast reconstruction. Subsection (02) of this regulation states:

> .02 Procedure Excluded. The costs of physician and hospital services for the following types of treatments are excluded from MA payment. . . .
>
> b. **Cosmetic surgery which is not medically necessary and is accomplished without prior approval of the MA Section of the Department.** [Emphasis added.]

Principles of statutory construction provide that "the plain, obvious and rational meaning is always to be preferred to any curious, narrow, hidden sense. [Citations omitted.]" Higginson v. Westergard, 100 Idaho 687, 691 (1979). Respondent argues that Subsection (02)(b) is to be construed in the alternative; that is,

if the procedure in question is either cosmetic or medically unnecessary, then it is excluded from coverage (if it is both noncosmetic and medically necessary, it is covered).

In the Court's opinion, under the plain language of this regulation, it is only medically unnecessary cosmetic surgery which is excluded from coverage. Thus, if the procedure is found to be noncosmetic, it does not fall within this exclusion. Likewise, if the procedure is cosmetic, but found to be medically necessary, it also does not fall within this exclusion.

If the Department had intended to exclude all cosmetic surgery from coverage, the regulation would read simply: "b. Cosmetic surgery." The phrase "which is not medically necessary" would have no meaning if Respondent's interpretation were applied. In Hartley v. Miller-Stephen, 107 Idaho 688, 690 (1984), the Idaho Supreme Court noted that it would "not construe a statute in a way which makes mere surplusage of the provisions included therein, [citations omitted]." This conclusion is supported by the language in an earlier United States Supreme Court decision, Beal v. Doe, 432 U.S. 438, 53 L.Ed.2d 464 (1977), in which the Court noted:

> Although serious statutory questions might be presented if a state Medicaid program excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary--though perhaps desirable--medical services. [Emphasis in original.]

53 L.Ed.2d at 472. Thus, regardless of whether or not the surgery in question is considered to be purely cosmetic, the procedure is

not excluded unless it is determined to be medically unnecessary.

The issue with which this Court is confronted, then, is how the Department should decide what constitutes "medically necessary" surgery in a given case. Medical necessity is the touchstone for evaluating the reasonableness of standards in state medicaid plans. Miller v. Department of Health and Welfare, No. 40204-C, memorandum op. at 5 (D.Idaho, June 28, 1989). The Court agrees that the Department is not required to unconditionally accept every opinion offered by a Medicaid recipient's treating physician. However, the legislative history, Medicaid case law, and the mechanics of the Medicaid program itself require that an attending physician's opinion as to what constitutes medical necessity in a given case be given deference.

The first suggestion of the role to be played by the recipient's treating physician comes out of the Congressional history of the Medicaid statute itself:

> The Committee's bill provides that the physician is to be the key figure in determining utilization of health services--and provides that it is physician who is to decide upon an admission to a hospital, or to tests, drugs and treatments, in determining the length of stay.

S.Rep. No. 404, 89 Cong., 1st Sess. reprinted in 1965 U.C. Code Cong. and Admin. News 1943, 1986. Many jurisdictions adhere to the conclusion that the treating physician is to play a "key role" in determining what constitutes medical necessity. In Rush v. Parnham, 625 F.2d 1150 (5th Cir. 1980), the court decided that the state agency's role was limited to the question of "determining whether the physician's diagnosis, or his opinion that the

prescribed treatment was appropriate to the diagnosis, was without any basis in fact." 625 F.2d at 1157. The Eighth Circuit court, in Weaver v. Reagan, 886 F.2d 194, 199, 200 (8th Cir. 1989) held as follows:

> Relying on Beal v. Does, . . .this court emphasized the importance of professional medical judgment in the determination of medical necessity. "The decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual physician and not with the clerical personnel or government officials." Pinneke v. Preisser, 623 F.2d at 550.
>
> * * *
>
> The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the tending physician in determining the medical necessity of treatment.

Likewise, the Ninth Circuit Court of Appeals in Vista Hill Foundation, Inc. v. Heckler, 767 F.2d 556, 560-61 (9th Cir. 1985), found that defining "what is medically necessary treatment does not appear to be one of those areas in which the Secretary [of Health and Welfare] has sufficient expertise that we should give unbridled deference to her interpretation. [Citation omitted.] Outside of the Medicare context, in related areas, courts have concluded that physicians, not administrative agencies, have responsibility for determining what constitutes medically necessary treatment. [Citations omitted.]"

This Court is persuaded by the aforementioned authorities that in this case the treating physician's opinion as to medical necessity is entitled to deference. The Court agrees with the reasoning used in a recent New York decision, State of New York v. Sullivan, 927 F.2d 57, 59-60 (2d Cir. 1991):

Initially, we agree with the Secretary that his rejection of

> coverage may not be set aside simply because it is at variance with the joint assessment of the attending physician and the URC. . . .[W]e will also follow Stein in leaving for the Secretary's initial consideration the issue of whether the treating physician rule, applicable to disability cases, . . .applies to Medicare coverage determinations. . . .[W]e would expect the Secretary to place significant reliance on the informed opinion of a treating physician and either to apply the treating physician rule, with its component of "some extra weight" to be accorded to that opinion, [cite omitted], or to supply a reasoned basis, in conformity with statutory purposes, for declining to do so.

See also Eastern Idaho Regional Medical Center v. Board of Commissioners of Bonneville County, 91.7 I.C.A.R. 474, 476 (1991). In conclusion, then, Respondent must give due deference to the treating physician's opinion, or provide a reasoned basis for declining to do so which is consistent with the purposes of the Medicaid Act.

Respondent's basis for denying coverage in this case hinges upon its definition of "cosmetic surgery." "Cosmetic surgery" was defined to be those procedures which neither improve function nor relieve pain, based upon a common-sense, dictionary definition of the term. Trial II., p. 28. Cosmetic surgery was seen as that surgery related to beautification and adornment. Respondent's Memorandum (October 28, 1991), p. 12. Appellant's definition of "cosmetic surgery," from the American Society of Plastic and Reconstructive Surgeons, was that performed "to reshape normal structures of the body in order to improve the patient's appearance and self-esteem." Appellant's Memorandum (June 12, 1991), p. 8.

Although dictionary definitions may be helpful in some situations to aid in defining undefined terms in a statute or

regulation, such definitions in the medical context should have only limited applicability. The Court deals here with medical terms applied in a medical context. This Court concludes that the commonplace definitions suggested by the Respondent are of limited guidance.

This Court is of the opinion that the reconstruction of Appellant's breasts in this case following a double mastectomy was a noncosmetic, medically necessary procedure. The Court finds support for its decision from numerous sources. Initially, Dr. Kenevan, Appellant's treating physician, testified that in his opinion, breast reconstruction was medically necessary and was, under no circumstances, cosmetic. Trial, p. 7. He noted that:

> Once you commit a patient to something, and I basically committed Kelly with regard to what I thought was appropriate treatment for her, it's very--it's not appropriate for me to suddenly back out just because of financial consideration.

Trial, p.17. As the treating physician's opinion is entitled to deference, this represents the most convincing evidence that the reconstructive surgery was medically necessary under the circumstances. Second, the American Society of Plastic and Reconstructive Surgeons, defines the surgery at issue in this case as reconstructive, not cosmetic: "[Reconstructive surgery is] performed on abnormal structures of the body caused by birth defects, infection, tumors, and disease." Trial, p. 9. Thus, there exists authority in the medical community for this Court's conclusion. Third, Appellant's own testimony suggests that the reconstruction was medically necessary for her health. Appellant

testified that:

> I just didn't feel like going on. I had no interest in my children. I had no interest in going out of my home. . . .I think--if it wouldn't have been performed, I believe right now I wouldn't be talking to you because I would have committed suicide. . . .I was that depressed when I found out and I don't think I would have had much to live for.

Trial, pp. 21-22. Dr. Kenevan testified that "psychological ramifications and medical ramifications are interwoven." Trial, p. 13. Even the agency physician, Dr. Montgomery, testified that Appellant's depression and thoughts of suicide indicated that the surgery was medically necessary. Trial II, p. 76. Finally, the CCH Medicare and Medicaid Guide, sec. 27,201, noted that the Federal Health Care Financing Administration (HCFA) which regulates Medicaid, considers breast reconstruction to be a noncosmetic procedure under the Medicare statute:

> During recent years there has been a considerable change in the treatment of carcinoma of the breast. . . .[T]he quality of life following initial treatment is increasingly recognized as of great concern. . . .Breast reconstruction following mastectomy is considered a relatively safe and effective noncosmetic procedure. Medicare and Medicaid Guide, sec. 27,201, p. 9010 (1987).

Because the Respondent had no rational basis upon which to disregard the expert opinion of Appellant's attending physician, especially in the face of evidence from both the medical community and the HCFA in support of this opinion, this Court must reverse as clearly erroneous under I.C. 67-5215(g)(5) the hearing officer's conclusion that Appellant's reconstructive surgery was medically unnecessary.

This Court concludes that the reconstructive surgery performed

on Appellant following her double mastectomy was a noncosmetic, medically necessary procedure. Therefore, the decision of the hearing officer is REVERSED, and the cause REMANDED for further proceedings consistent with this decision. It is so ORDERED.

DATED this 12th day of February, 1992.

Ron Schilling - District Judge

CERTIFICATE OF MAILING

I hereby certify that a true copy of the foregoing MEMORANDUM DECISION AND ORDER was mailed, postage prepaid, by the undersigned at Lewiston, Idaho, this 27th day of February, 1992, on:

Randall Robinson
P.O. Box 973
Lewiston, ID 83501-0973

Edward Lockwood
1118 Ironwood Drive
Coeur d'Alene, ID 83814

BETTY J. WILSEY, CLERK

By: NANCY WAGNER
Deputy

Decision & Order
2-27-92

plan, all services under the plan that are pregnancy-related for an extended postpartum period. The postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(b) A State plan must specify that eligible aliens as defined in §§ 435.406(a) and 436.406(a) of this subchapter will receive at least the services provided in paragraph (a) of this section.

(c) A State plan must specify that aliens not defined in §§ 435.406(a) and 436.406(a) of this subchapter will only be provided the limited services specified in § 440.255.

[56 FR 24010, May 28, 1991]

§ 440.220 Required services for the medically needy.

(a) A State plan that includes the medically needy must specify that the medically needy are provided, as a minimum, the following services:

(1) Prenatal care and delivery services for pregnant women.

(2) Ambulatory services, as defined in the State plan, for—

(i) Individuals under age 18; and

(ii) Individuals entitled to institutional services.

(3) Home health services (§ 440.70) to any individual entitled to skilled nursing facility services.

(4) If the State plan includes services in an institution for mental diseases (§ 440.140 or § 440.160) or in an intermediate care facility for the mentally retarded (§ 440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(i) The services contained in §§ 440.10 through 440.50 and (to the extent nurse-midwives are authorized to practice under State law or regulation) § 440.165; or

(ii) The services contained in any seven of the sections in §§ 440.10 through 440.165.

(5) For women who, while pregnant, applied for, were eligible as medically needy for, and received Medicaid services under the plan, services under the plan that are pregnancy-related (as defined in § 440.210(a)(2)(i) of this subpart) for an extended postpartum period. The postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(b) A State plan must specify that eligible aliens as defined in §§ 435.406(a) and 436.406(a) of this subchapter will receive at least the services provided in paragraphs (a)(4)(i) and (ii) of this section.

(c) A State plan must specify that aliens defined in §§ 435.406(b), 435.406(c), 436.406(b) and 436.406(c) of this subchapter will only be provided the limited services specified in § 440.255.

[56 FR 24011, May 28, 1991]

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

[46 FR 47993, Sept. 30, 1981]

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in

provide consistency in determining payment for services provided by physicians and noninstitutional providers.

I. "Intensive, inpatient hospital rehabilitation service" means an intense rehabilitation program provided in an acute care general hospital through the services of a multidisciplinary, coordinated, team approach directed toward upgrading ability of the patient to function.

J. "Package surgical procedures" means preoperative office visits and preparation, the operation per se, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow-up care extending for up to six weeks post surgery.

K. "Patient" means an individual who is receiving covered professional services provided or directed by a licensed practitioner of the healing arts enrolled as a Medicaid provider.

L. "Personal supervision" means the critical observation and guidance of medical services by a physician of a nonphysician's activities within that nonphysician's licensed scope of practice.

M. "Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility or elsewhere, means services provided:

a) within the scope of practice of medicine or osteopathy as defined by State law; and

b) by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

N. "Prior authorization" means the required approval for provision of a service which the provider must obtain from the Division of Health Care Financing before providing that service.

O. "Professional component" means that part of laboratory or radiology service which may be provided only by the physician pathologist or radiologist using professional skill and judgment to complete the analysis of a procedure or service and provide a written report of findings.

P. "Provider" means an entity or a licensed practitioner of the healing arts providing approved Medicaid services to patients under a provider agreement with the Division of Health Care Financing.

Q. "Services" means the types of medical assistance specified in sections 1905(a)(1) through (18) of the Social Security Act and interpreted in the 42 CFR Section 440, 1989 edition, which is hereby incorporated by reference.

R. "Technical component" means that part of laboratory or radiology service necessary to secure a specimen and prepare it for analysis or to take an x-ray and prepare it for reading and interpretation.

R414-10-4. Client Eligibility Requirements.

Physicians' services are available to categorically eligible and medically needy individuals.

R414-10-5. Program Access Requirements.

A. Physicians' services are available only from a physician who meets all requirements necessary to participate in the Utah Medicaid Program and who has signed a provider agreement.

B. Physicians' services are available only from a physician who renders medically necessary physician services in accordance with his specific provider agreement and with Utah Department of Health rules.

C. An eligible Medicaid client may seek physician services from:

1. a physician in private practice who is an enrolled Medicaid provider;

2. a Health Maintenance Organization (HMO) which has a contract with the Division of Health Care Financing;

3. a federally qualified community health center; or

4. other organized practice setting recognized by the Division of Health Care Financing for providing physician services.

R414-10-6. Service Coverage.

A. Physician services involve direct patient care and securing and supervising appropriate diagnostic ancillary tests or services in order to diagnose the existence, nature or extent of illness, injury or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, infirmity, deformity or other impairments to a client's physical or mental health.

B. Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions established by the Division of Health Care Financing on the basis of medical necessity, appropriateness and utilization control considerations.

C. Program limitations and noncovered services are established by specific program policy, maintained in the Physician Provider Manual and updated by notification through Medicaid Provider Bulletins. Following is a general list of medical and health care services excluded from coverage:

1. Services rendered during a period the recipient was ineligible for Medicaid.

2. Services medically unnecessary or unreasonable.

3. Services which fail to meet existing standards of professional practice, or which are currently professionally unacceptable.

4. Services requiring prior authorization, but for which such authorization was not received.

5. Services, elective in nature, based on patient request or individual preference rather than medical necessity.

6. Services fraudulently claimed.

7. Services which represent abuse or overuse.

8. Services rejected or disallowed by Medicare when the rejection was based upon any of the reasons set forth above.

D. Experimental or medically unproven physician services or procedures are excluded from coverage. Criteria established and approved by the Division of Health Care Financing staff and physician consultants are used to identify noncovered services and procedures. Policy statements developed by the Department of Health and Human Services, Health Care Financing Administration, Coverage Issues Bureau shall also be used to determine Utah Department of Health, Division of Health Care Financing policy for noncovered services.

E. Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the services cannot be assured. A variety of lifestyle factors contribute to the "syndromes" associated with such services, and there is no specific therapy or treatment identified except for those which border on behavior modification, experimental, or unproven practices. Services include:

1. Sleep apnea or sleep studies, or both;

2. Pain clinics; and

3. Eating disorders clinics.

F. When a service or procedure does not qualify for coverage under the Medicaid program because it is an elective cosmetic, reconstructive or plastic surgery,

all related services, supplies, and institutional costs are excluded from coverage.

G. Medications for appetite suppression, surgical procedures, unproven or experimental treatments, or educational, nutritional support programs for the treatment of obesity or weight control are excluded from coverage.

H. Cognitive or Office Services

1. Cognitive Services are limited to one service per client per day per provider. These services are defined as office visits, hospital visits except for those following a package surgical procedure, therapy visits and other types of nonsurgical services. When a second office visit for the same problem or a hospital admission occurs on the same date as another service, the physician shall combine the services as one service and select a procedure code to indicate the overall care given.

2. Routine physical examinations, not part of an otherwise medically necessary service, are excluded from coverage as a Medicaid benefit, except in the following circumstances:

a. Preschool and school age children, including those who are EPSDT (CHEC) eligible, under the age of 21, participating in the ongoing CHEC program of scheduled services and follow-up care.

b. New patients seeing a physician for the first time with an initial complaint where a comprehensive physical examination, including a medical and social history, is necessary.

c. Medically necessary examinations associated with birth control medication, devices, and instructions.

3. Family planning services may be provided only by or under the supervision of a physician and only to individuals of childbearing age, including sexually active minors. The following services are excluded from coverage as family planning services:

a. Experimental or unproven medical procedures, practices, or medication.

b. Surgical procedures for the reversal of previous elective sterilization, both male and female.

c. Infertility studies.

d. In-vitro fertilization.

e. Artificial insemination.

f. Surrogate motherhood, including all services, tests and related charges.

g. Abortion, specifically for the purpose of terminating a pregnancy when there is no medical certification of necessity as described in Title 42 of the Code of Federal Regulations, Section 441.203.

4. After-hours service codes may be used only by a private physician, primary care provider, who responds to treat a patient in the physician's private office for a medical emergency, accident or injury after regular office hours. Only one of the after hours CPT codes may be used per visit.

5. Only the laboratory tests in the following list are covered as part of a physician's office service. All other laboratory services shall be provided by an independent laboratory. The independent laboratory completing the service must bill the Division of Health Care Financing directly to receive payment for the service.

a. 81000 Urinalysis by reagent strips, any number of components: with microscopy.

b. 81002 Urinalysis without microscopy

c. 82270 Blood: occult, feces, screening

d. 82948 Glucose: blood, stick test

e. 84702 Gonadotropin, chorionic: quantitative

f. 84703 Gonadotropin, chorionic: qualitative

g. 85007 Blood count: manual differential WBC (includes RBC morphology and platelet estimation)

h. 85014 Blood count: hematocrit

i. 85021 Blood count: hemogram, automated (RBC, WBC, HgB, Hct and indices only)

j. 85022 Blood count: hemogram, automated, and manual differential WBC count (CBC)

k. 85023 Blood count: hemogram and platelet count, automated, and manual differential WBC count (CBC)

l. 85024 Blood count: hemogram and platelet count, automated, and automated partial differential WBC count (CBC)

m. 85025 Blood count: hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

n. 85027 Blood count: hemogram and platelet count, automated

o. 85031 Blood count: hemogram, manual, complete CBC (RBC, WBC, HgB, Hct, differential and indices)

p. 85048 Blood Count: white blood cell (WBC)

q. 85650 Sedimentation rate (ESR): Wintrobe type

r. 85651 Sedimentation rate: Westergren type

s. 86300 Heterophile antibodies: screening (includes monotype test) slide or tube

t. 86317 Immunoassay for infectious agent antigen or antibody, each

u. 86403 Particle agglutination, rapid test for infectious agent, each antigen

v. 86580 Skin test: tuberculosis, intradermal

w. 86585 Skin test: tuberculosis, tine test

x. 87081 Culture, bacterial, screening only, for single organisms

y. 87082 Culture, presumptive, pathogenic organisms, screening only, by commercial kit; for single organisms

z. 87210 Smear, primary source: wet mount with simple stain, for bacteria, fungi ova and parasites

aa. 87220 Tissue examination for fungi (e.g., KOH slide)

6. In addition to the above laboratory services, the following services are covered when a private physician personally collects the specimen:

a. 85095 Bone marrow smear or cell block or both: aspiration only

b. 85102 Bone marrow biopsy, needle or trocar

7. A specimen collection fee is covered for service in a physician's office only when a specimen is to be sent to an outside laboratory, and the physician or one of his office staff under his personal supervision actually extracts the specimen from a patient and only by one of the following procedures:

a. Drawing a blood sample through venipuncture, i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen; or

b. Collecting a urine sample by catheterization.

8. Eye examinations are covered, but only once each calendar year.

9. Contact lenses are covered only for aphakia, nystagmus, keratoconus, severe corneal distortion, cataract surgery, and in those cases where visual acuity cannot be corrected to 20/70 in the better eye.

I. Psychiatric Services

1. Psychiatric services or psychosocial diagnosis and counseling are specialty medical services. Psychiatric services whether in a private office, a group practice, or private clinic setting may only be provided directly and documented and billed to Health Care Financing by the private physician. Charting and documentation must clearly reflect the private physician's direct provision of care.

2. Nonphysician psychosocial counseling services are excluded from coverage as a Medicaid benefit. The personal supervision policy, Utah Administrative Code, R414-45-1, may not be applied to psychiatric services.

3. Admission to a general hospital for psychiatric care by a physician requires prior authorization and is limited to those cases determined by established criteria and utilization review standards to be of a severity that appropriate intensity of service cannot be provided in any alternate setting.

J. Laboratory and Radiology Services

1. Laboratory services identified by CPT codes 80000 through 89999, and radiology services identified by CPT codes 70000 through 79999 are ancillary medical services with both a technical and professional component. The professional component, i.e., analysis, interpretation and written report, represented by modifier 26, may be provided only by a pathologist or a radiologist practicing in an independent or hospital laboratory or radiology setting. Private physicians who are not pathologists or radiologists may not bill for the service described by modifier 26 for telling a patient the results of laboratory or radiology procedures as noted on the laboratory or radiology printout or the written report. Providing such information to the patient is part of the office call rather than a separate service.

2. Physicians prepared in a highly specialized field of practice, e.g., neurology or neurosurgery, who provide consultation and diagnostic radiology services in an independent setting at the request of a private physician may bill for both the technical and professional component of the radiology service.

K. Hospital Services

1. A patient hospitalized for nonsurgical services may require more than one visit per day because of the patient's condition and treatment needs. Since physician visits are limited to one per day, the physician shall select one procedure code to define the overall care given. If intensive care services are provided, or critical care service codes are used to define service provided, additional documentation by the physician is required. The medical record must show documentation of medical necessity and result of the additional service.

2. When, for the convenience of the physician and not for medical necessity, a patient is transferred between physicians within the same hospital or from one hospital to another hospital, both physicians may only use subsequent hospital care service codes to define and bill for services provided. Under this policy limitation, services associated with the following codes are excluded from coverage as a Medicaid benefit:

a. Consultation; and

b. Initial hospital care services.

3. Treatment of alcoholism or drug dependency in an inpatient setting is limited to acute care for detoxification only.

L. Abortion, Sterilization and Hysterectomy

1. Abortion procedures are limited only to those with medical certification of necessity as described in 42 CFR 441.203, October 1989 edition, which is hereby incorporated by reference.

2. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F, October, 1989, which is hereby incorporated by reference.

M. Cosmetic, Plastic, or Reconstructive Services

1. Cosmetic, plastic, or reconstructive surgery procedures may only be covered when medically necessary to:

a. correct a congenital anomaly;

b. restore body form or function following an accidental injury; or

c. revise severe disfiguring and extensive scarring resulting from neoplastic surgery.

N. Surgical Services

1. Surgical procedures defined and coded in the CPT Manual are limited by Utah Medicaid policy to place of service, to prior authorization, or are excluded from coverage. Limitations are documented on the Medical and Surgical Procedures Prior Authorization List, reviewed and revised yearly and maintained in the Physician Provider Manual through notification by Provider Bulletins.

2. Surgical procedures are "package" services. The package service includes:

a. the preoperative examination, initiation of the hospital record, and development of a treatment program either in the physician's office on the day before admission, or in the hospital or the physician's office on the same day as admission to the hospital;

b. the operation per se;

c. any topical, local or regional anesthesia; and

d. the normal, uncomplicated follow-up care covering the period of hospitalization and office follow-up for progress checks or any service directly related to the surgical procedure for up to six weeks post surgery.

3. Interpretation of "package" services:

a. There may not be any additional billings by the physician for an office visit the day prior to surgery; for preadmission or admission workup; or for subsequent hospital care while the patient is being prepared, hospitalized, or under care for a "package" surgical service.

b. Consultation services may be billed by the consulting physician only when consultation and no other service is provided. When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, only admission codes and subsequent care codes may be used.

c. Office visits for up to six weeks following the hospitalization which relate to the same diagnosis are part of the "package" service. The only exception to either inpatient or office service is for service related to complications, exacerbations, or recurrence of other diseases or problems requiring additional or separate service.

4. Procedures exempt from the "package" definition are identified in the CPT Manual, 1991 edition, by an asterisk. The CPT Manual outlines the surgical guidelines which apply to documentation and billing of procedures marked by an asterisk.

5. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring services concurrent with the initial surgical procedure during the listed period of normal follow-up care may warrant additional charges only when the record shows extensive documentation and justification of additional services.

6. When an additional surgical procedure is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods continue concurrently to their normal terminations.

7. Preoperative examination and planning are covered as separate services only in the following circumstances:

a. When the preoperative visit is the initial visit for the physician and prolonged detention or evaluation

is required to establish a diagnosis, determine the need for a specific surgical procedure, or prepare the patient;

b. When the preoperative visit is a consultation and the consulting physician does not assume care of the patient; or

c. When diagnostic procedures, not part of the basic surgical procedure, e.g., bronchoscopy prior to chest surgery, are provided during the immediate preoperative period.

8. Exploratory Laparotomy procedures confirm a diagnosis and determine the extent of necessary treatment. Payment may be requested by a physician only if the exploratory procedure is the only procedure done during an operative session. Exploratory laparotomy services identified by CPT Codes 49000-49060 may not be billed in conjunction with any services identified by the following CPT Codes: 43500 - 44346 - 44600 - 45180 - 47400 - 47490 - 47600 - 48999 - 49002 - 49999 - 58140 - 58285 - 58400 - 58960.

9. The services of an assistant surgeon are covered only on very complex surgical procedures. Procedures not authorized for assistant surgeon coverage are listed in the Physician Provider Manual and updated by Medicaid Provider Bulletins as necessary. Medicare guidelines for limitation of assistant surgeon coverage are used, since those decisions are made at the national level with physician consultation.

O. Diagnostic and Therapeutic Procedures

1. Diagnostic needle procedures, e.g., lumbar puncture; thoracentesis; and jugular, femoral vein, or subdural taps, when performed as part of a necessary workup for a serious medical illness or injury, are covered in addition to other medical care on the same day.

2. Diagnostic "oscopy" procedures, e.g., endoscopy, bronchoscopy, and laparoscopy, are covered separately from any major surgical procedure. However, when an "oscopy" procedure is done the same day or at the same operative session as another procedure, the "oscopy" procedure may only be covered as a multiple procedure.

3. Magnetic resonance imaging (MRI) is covered only for service to the brain, spinal cord, hip, thigh and abdomen.

4. Therapeutic needle procedures, e.g., scalp vein insertion, injections into cavities, nerve blocks, are covered in addition to other medical care on the same day.

5. Puncture of a cavity or joint for aspiration followed by injection of a medication is covered as one procedure and identified by specific CPT code.

P. Anesthesia Services

Anesthesia services are covered only when administered by a licensed anesthesiologist or nurse anesthetist who remains in attendance for the sole purpose of rendering general anesthesia services. Standby or monitoring by the anesthesiologist or anesthetist during local anesthesia is not a covered Medicaid anesthesia service.

Q. Transplant Services

Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in Utah Administrative Code R414-10A.

R. Modifiers

1. Modifiers may be used only as defined in the CPT Manual, 1991 edition, to show that a service or procedure has been altered to some degree but not changed in definition or code. The following limitations apply:

a. The professional component, modifier 26, may be used only with laboratory and radiology service codes by a pathologist or radiologist and only when direct analysis, interpretation, and written report of findings are provided on a laboratory or radiology procedure. Private physicians may not use this modifier.

b. Unusual services are identified by use of modifier 22 along with the appropriate CPT code. A prepayment review of unusual services shall be completed by Medicaid professional staff or physician consultants. A report of the service and any important supporting documentation must be submitted with the claim for review.

c. Anesthesia by surgeon is identified by use of modifier 47. The operating surgeon may not use modifier 47 in addition to the basic procedure code. Anesthesia provided by the surgeon is part of the basic procedure being provided.

d. Mandated services as defined by CPT and identified by modifier 32 are noncovered for Medicaid service.

e. Reference laboratory services identified by modifier 90 are noncovered for Medicaid service.

S. Medications

1. Drugs and biologicals are limited to those approved by the Food and Drug Administration (FDA). Medicaid coverage of drugs and biologicals is based on individual need and orders written by a physician when the drug is given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug.

a. Generic drugs shall be used whenever a generic product approved by the FDA is available. If the physician determines that a brand name drug is medically necessary, the physician may override the generic requirement by writing on the prescription in his own hand writing "name brand medically necessary". Preprinted messages, abbreviations or notations by a second party do not meet the override requirement. The pharmacist shall fill the prescription with the generic equivalent product if the override procedure is not followed.

b. Injectable medications approved in HCPCS are identified in the "J" code list published by the Health Care Financing Administration or the Utah Department of Health, Division of Health Care Financing or both. The list is reviewed and revised yearly and maintained in the Physician Provider Manual by notification and update through Medicaid Provider Bulletins.

c. The "J" code covers only the cost of an approved product.

d. Office visits only for administration of medication are excluded from coverage. However, an injection code which covers the cost of the syringe, needle and administration of the medication may be used with the "J" code when medication administration is the only reason for an office call.

e. When an office service is provided for other purposes, in addition to medication administration, only the office visit and a "J" code may be used to bill for the service provided.

f. The office visit code and injection code may never be used together. Only one of the codes may be used to define the service provided.

g. Vitamin B-12 is limited to use only in treating conditions where physiological mechanisms produce pernicious anemia. Use of Vitamin B-12 in treating any unrelated condition is excluded from coverage.

2. Vitamins may be provided only for:

a. Pregnant women: Prenatal vitamins with 1 mg folic acid.

b. Children through age 5: Childrens' vitamins with fluoride.
2. Children through age 15: Fluoride supplement.
3. Human growth stimulating hormones are not a covered Medicaid benefit.
4. Methylphenidates, amphetamines, and other central nervous system stimulants require prior authorization and may be provided only for treatment of Attention Deficit Disorder (ADD) in children between the ages of 6 and 18 years.
5. Medications for appetite suppression are not a benefit of the Medicaid program.
6. Non-prescription, over-the-counter items are limited and notification of changes consistent with this rule are made by Provider Bulletin and Provider Manual updates.
7. Nutrients may be provided only as established in Utah Medicaid intravenous therapy rules.

R414-10-7. Prior Authorization.

A. Selected medical and surgical procedures, as documented in the Medical and Surgical Procedures Prior Authorization List, and incorporated in individual provider agreements, require prior authorization.

B. Prior authorization, consent, and other supporting documentation are required for medical necessity and appropriateness of sterilization, hysterectomy and abortion procedures to be established by the Bureau of Managed Health Care, Utilization Management staff. This is required by 42 CFR Part 441, Subparts E and F, October 1989 edition.

C. The Medical and Surgical Procedures Prior Authorization List, maintained in the Physician Provider Manual and updated by Medicaid Provider Bulletins as necessary, defines the prior authorization requirements for specific procedures referenced in A and B above.

D. Telephone Prior Authorization is available for selected procedures. The Medical and Surgical Procedures Prior Authorization List identifies the procedures and the requirements for telephone prior authorization.

E. All inpatient hospital psychiatric services require prior authorization.

F. Outpatient Psychiatric services, provided by an individual physician provider, require prior authorization after the first 12 services in each calendar year.

G. Surgical procedures which require prior authorization and are performed under emergency circumstances require an "after-the-fact authorization." The procedures to follow when seeking such an authorization are found on the introductory key to the Medical and Surgical Procedures Prior Authorization List.

H. All services related to organ transplant procedures require prior authorization. An "after-the-fact authorization" may not be considered.

I. Intensive, inpatient hospital physical rehabilitation services require prior authorization.

R414-10-8. Reimbursement.

A. Reimbursement for physician services may be provided only in accordance with a specific provider agreement.

B. The physician may seek reimbursement, in accordance with Utah Administrative Code R414-45-1 and R414-45-2, only for services that were personally rendered by the physician or were rendered incident to the physician's professional service by a physician in training, a nurse practitioner, or a physician assistant under personal supervision. The acceptable standard for personal supervision is availability by telephone, when the physician has a written protocol embodying supervisory procedures. The personal supervision requirement must be met with respect to every nonphysician service provided in the course of treatment prescribed by any physician for any Medicaid client. Medical charts must have signed documentation sufficient to reflect active participation of the physician in managing, providing and supervising all aspects of patient care and treatment.

C. In accordance with Utah Administrative Code R414-4x, payment may be made only when a covered service has been provided directly to a patient. Reimbursement may not be requested when a patient fails to keep a scheduled appointment.

1991 **26-1-5, 26-18-3**

R414-10A. Selected Transplantation Services: Standards and Criteria for Patient Selection.

R414-10A-1. Policy Statement.

A. This rule establishes standards and criteria for bone marrow, cornea, heart, kidney and liver transplantation in the treatment of progressive, or life threatening disease.

B. Selected transplantation services include inpatient hospital, physician, laboratory, outpatient surgical, and other approved services necessary to accomplish selected transplantation.

R414-10A-2. Authority.

Selected transplantation services are optional Medicaid, Title XIX services. Section 9507 of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), codified as section 1903(i)(1) of the Social Security Act, requires states, as part of the Medicaid program, to establish standards for coverage of selected transplantation services.

R414-10A-3. Definitions.

For purposes of R414-10A:

A. "Abstinence" means the documented non-use of any abusable psychoactive substance.

B. "Active infection" means current presumptive evidence of invasion of tissue or body fluids by bacteria, viruses, fungi, rickettsiae, or parasites which is not demonstrated to be effectively controlled by the host, antibiotic or antimicrobial agents.

mentation to support the need for additional units. The request shall include at least the following:

1. documentation of the course of the recipient's illness and treatment and a complete summary of the recipient's current condition including symptomalogy and behavior for which additional service units are requested;

2. documentation of initial DSM III diagnoses on Axes I-V and any change in these diagnoses;

3. an estimate of the number of additional service units required and an explanation of how additional service units will be useful in treating the recipient's condition;

4. a statement outlining other alternatives considered or utilized;

5. a copy of treatment plan and a statement of how it will serve to improve the client's condition;

6. the dates of service for which authorization is requested.

B. Criteria for Prior Authorization

Day treatment - To obtain authorization, the provider shall document the recipient meets one of the following criteria:

1. a current GAS rating or GAF rating on Axis V of the DSM III-R of 30 or under;

2. a rating of 40 or under on the GAF Scale for the last 6-12 months;

3. a history of psychiatric illness or psychiatric hospitalizations and corresponding evidence that the increased levels of day treatment requested will maintain or improve current levels of functioning.

4. Three of the following:

(a) a marked deterioration or worsening of the recipient's condition, as evidenced by an increase in symptomatology or behavior related to the diagnosis and a decrease in ability to maintain previous level of functioning;

(b) a change in diagnosis on Axis I and/or V of the DSM III-R indicating the recipient can no longer carry out activities as he had previously and that he is at increased risk for inpatient care;

(c) specific evidence of increased risk of suicide or destructive behavior toward self or others;

(d) a release from an institutional setting within the last 60 days and corresponding need for additional day treatment hours to maintain gains and make a successful transition to the community.

(e) a history of acute episodes or hospitalizations during the past year.

R414-25-9. Reimbursement Method for Clinic Services.

Payment for Clinic Services is limited to the amount paid by Medicare as specified in 42 CFR 447.321.

A. Payment for covered services will be made to qualified providers.

B. Payment for covered services will be made on a fee-for-service basis according to the following methodology:

1. Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the reasonable cost of providing the service; or (3) the established fee schedule.

2. The usual and customary charge is the lower of the most frequently billed gross charge prior to discounts, or the charge billed to insurance companies.

3. The cost of providing services is calculated by taking a ratio of Medicaid charges to total charges. This ratio is applied to the total allowable costs that correspond to the billable services. Reasonable costs are defined in the "Medicare Provider Reimbursement Manual," HCFA Publication 15-1 and the Utah State Plan.

4. All mental health clinic services will be billed using approved HCPC codes.

5. On an annual basis, total Medicaid payments to the provider will be adjusted, as necessary, so that aggregate payments are limited to reasonable cost as determined by a fiscal audit.

1989 **26-1-4.1, 26-1-5, 26-18-3**

R414-25x. Policy Concerning the Time Frame in Which Medicaid Claims Must be Submitted for Payment.

R414-25x-1.

R414-25x-1.

Effective January 1, 1982:

For claims with dates of service (or first dates of service) on or after July 1, 1981, the Medicaid claims payment policy will be as follows:

- Payment for services will be made only if claims are submitted to Medicaid within 12 months from the date of service (or first date of service).

For Medicaid/Medicare crossover, claims with dates of payment on or after July 1, 1981, the new Medicaid claims payment policy will be as follows:

- Payment will be made for Medicare/Medicaid "crossover claims" only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation Of Medical Benefits (E.O.M.B.).

1987 **26-1-5**

Notice of Continuation 1992

R414-26. Implementation and Maintenance of the Health Care Financing Administration Common Procedure Coding System (HCPCS).

R414-26-1. Policy.

R414-26-1. Policy.

1. The rule entitled "Health Common Procedure Coding System" (HCPCS), published in the Federal Register Vol. 50, No. 194, Monday, October 7, 1985, is incorporated by reference, and will become effective no later than November 1, 1986. Specific effective dates which apply to each program will be identified as the scope of service is reviewed, revised and the specific codes identified for each service.

2. The following sections are the modifications of this rule that apply to Utah.

a. The CPT-4 Manual with the accompanying descriptive terms, identifying codes and instructions will be limited to use only by physicians to identify the code medical services and procedures provided to a patient by the Physician. (Other providers as identified and limited by CFR 405.232 (a) may be authorized to use selected CPT-4 codes, but only if HCPCS codes are not available for the specialty.)

b. Providers of service other than physician services, covered by the Medicaid program will use the HCPCS codes developed by the Health Care Financing Administration specifically for the service provided by the specialty.

Laboratory and x-ray services listed in the CPT-4 Manual are special diagnostic services provided by a

der the direction of a Physician pathologist or radiologist.

e. Policy staff will have the responsibility to review each new edition of the CPT-4 Manual and each new publication of HCPCS codes for the other specialties. The purpose of this review will be to identify new services, eliminated services or procedures, and altered descriptions of service. Where additions, deletions, and/or changes have occurred, research will be initiated with subsequent development of appropriate policy recommendations and rulemaking to establish service coverage and/or limitations determined to be appropriate for Medicaid.

d. Policy staff will have the responsibility to review "X" codes established by Blue Cross, "S" codes established by the Utah Medical Association, and "Z" codes established by Medicare to determine appropriate service coverage and/or Limitations for Medicaid.

ICD9-CM diagnosis or surgical procedure codes will also be reviewed and evaluated by Policy staff.

Policy recommendations and rulemaking will be initiated when indicated.

e. Policy staff will have the responsibility for assignment and review of "Y" codes which are specific to Medicaid. Policy recommendations and rulemaking will be initiated as indicated.

f. No service, procedure, technology or individual code will be added, covered or deleted without benefit of the established policy development process.

Health Care Financing has the option to limit the amount, duration, or scope of services or to exclude a service or procedure from coverage by Medicaid. Policy recommendations will be based on medical necessity, appropriateness, utilization control concerns (CFR 440.230) and will take into consideration the following:

Existing policy for noncoverage of cosmetic, experimental or nonproven medical practices.

Information available from the Special Coverage Issues Bureau; Bureau of Eligibility, Reimbursement, and Coverage; Health Care Financing Administration; Department of Health and Human Services.

Information and recommendations from physician consultants employed by Utah Department of Health, Division of Health Care Financing.

Consultation with appropriate groups or individuals from various professional organizations.

Legal Counsel

Consultation with policy staff of the local Medicare carrier.

Consultation with policy staff of Medicaid programs in other states (selected).

Other sources determined appropriate by the specific issue being addressed.

1987 **26-1-5**

Notice of Continuation 1992

R414-27. Medicare Nursing Home Certification.

R414-27-1.

R414-27-1.

All skilled nursing homes must be certified for Medicare participation as a condition of Medicaid certification. The effects of this rule will be to enable more third-party collections (Medicare) and reduce Medicaid nursing home payments.

1987 **26-1-5**

Notice of Continuation 1992

R414-28. Record Keeping and Disclosure for Medicaid Providers.

R414-28-1.

R414-28-1.

1. As a condition of participation in the Medicaid program and receipt of Medicaid funds every provider is required:

(a) To maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid recipients and billed, charged, or reported to the State under Utah's Title XIX program;

(b) To promptly disclose or furnish upon request all information regarding any payment claimed for providing Medicaid services and any other information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing such health care services or services of the same nature or during the same period as services provided in Title XIX to recipients, as the State and its designees, the fraud control unit, or the Secretary of the United States Department of Health and Human Services may request;

(c) To allow for reasonable inspection and audit of financial or patient medical records for non-Title XIX recipients to the extent necessary to verify usual and customary expenses and charges.

2. In accordance with Archives and Records and Information Practices Act, Section 63-2-61 (13) et seq., U.C.A. (1953), any information gained from patient records (which are confidential) will be classified as Confidential and will be protected pursuant to the guidelines established by law in order to protect the privacy rights of the patients.

3. Request for access to or inspection of documents and records must be promptly and reasonably complied with, and access to a provider's records and facility at reasonable times and places must be granted to the agents of the State. Providers must not obstruct any audit or investigation, including the relevant questioning of employees of provider.

4. Where services, for which the Medicaid program provided reimbursement, cannot be verified by adequate records as having been furnished, or where a provider unreasonably refuses to provide or grant access to records as described above, any payments received by the provider for such undocumented services will be promptly refunded to the State, or the State may elect to deduct an equal amount from future reimbursements.

5. Repeated willful or unreasonable refusal to provide or grant access to the records as described above will result in the termination of the existing Medicaid provider agreement or other legal action.

1987 **26-1-5**

Notice of Continuation 1992

R414-29. Recipient Review/Education and Restriction Policy.

R414-29-1.

R414-29-1.

1. Purpose of Recipient Review/Education and Restriction (RRERP)

The primary purpose of recipient review/education and restriction is to educate recipients about appropriate use of health care services.

(d) **Effect of non-compliance with rule.** The clerk shall examine all briefs before filing. If they are not prepared in accordance with this rule, they will not be filed but shall be returned to be properly prepared. The clerk may permit variance from this rule for good cause.
(Amended effective October 1, 1992.)

Amendment Notes. — The 1992 amendment, effective October 1, 1992, substituted "heavy cover stock" for "heavy stock" in the second sentence in Subdivision (c).

Rule 29. Oral argument.

(a) **In general.** Oral argument will be allowed in all cases unless the court concludes:

(1) The appeal is frivolous; or

(2) The dispositive issue or set of issues has been recently authoritatively decided; or

(3) The facts and legal arguments are adequately presented in the briefs and record and the decisional process would not be significantly aided by oral argument.

(b) **Priority of argument.** Cases shall be scheduled for oral argument in accordance with the following list of priorities:

(1) Appeals from convictions in which the death penalty has been imposed;

(2) Appeals from convictions in all other criminal matters with priority to cases in which the defendant is incarcerated;

(3) Appeals from habeas corpus petitions and other post-conviction proceedings;

(4) Appeals from orders concerning child custody or termination of parental rights;

(5) Matters relating to the discipline of attorneys;

(6) Matters relating to applicants who have failed to pass the bar examination;

(7) Petitions for review of Industrial Commission orders;

(8) Appeals from the orders of the Juvenile Court;

(9) Appeals from actions involving public elections;

(10) Appeals from interlocutory orders;

(11) Questions certified to the Supreme Court by a court of the United States;

(12) Original writ proceedings;

(13) Petitions for certiorari that have been granted;

(14) Petitions to review administrative agency orders not included within other categories; and

(15) Any matter not included within the above categories.

(c) **Notice by clerk and request by a party for argument; postponement.** Not later than 30 days prior to the term of court in which a case is to be submitted, the clerk shall give notice to all parties that oral argument is to be permitted, the time and place of oral argument, and the time to be allowed each side. Oral argument shall proceed as scheduled unless all parties waive the same in writing filed with the clerk not later than 15 days from the date of the clerk's notice. A request for postponement of the argument or for allow-

Pub. L. 100-360, § 411(f)(10)(A)(iii), as amended by Pub. L. 100-360, § 608(d)(21)(E), inserted before period at end "if a State requests that the individual not be excluded".

Pub. L. 100-360, § 411(f)(10)(A)(ii), substituted "exclude" for "bar".

Subsec. (b). Pub. L. 100-360, § 411(f)(10)(C)(i)(V), as amended by Pub. L. 100-485, § 608(d)(21)(F)(i), substituted "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section" for ", and (2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act".

Subsec. (b)(1). Pub. L. 100-360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100-485, § 608(d)(21)(G), substituted "an individual" for "a physician".

Subsec. (b)(2). Pub. L. 100-360, § 411(f)(10)(C)(i)(VI), as amended by Pub. L. 100-485, § 608(d)(21)(F)(i), added par. (2).

Subsec. (d)(1). Pub. L. 100-360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100-485, § 608(d)(21)(G), substituted "an individual" for "a physician".

Subsec. (d)(2). Pub. L. 100-360, § 411(f)(10)(C)(i)(VII), as added by Pub. L. 100-485, § 608(d)(21)(F), substituted "continues" for "continued".

Pub. L. 100-380, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100-485, § 608(d)(21)(G), substituted "individual" for "physician" in three places.

Subsec. (d)(4) to (6). Pub. L. 100-360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100-485, § 608(d)(21)(G), substituted "individual" for "physician" wherever appearing.

Subsec. (e). Pub. L. 100-360, § 411(f)(10)(C)(i)(II), as amended by Pub. L. 100-485, § 808(d)(21)(G), substituted "individual" for "physician" in two places.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 606(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(f)(10)(A) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-380, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Amendment by section 411(f)(10)(C)(i) of Pub. L. 100-360 effective 30 days after July 1, 1988, see section 411(f)(10)(C)(iii) of Pub. L. 100-380, set out as a note under section 294f of this title.

EFFECTIVE DATE

Section 4052(c) of Pub. L. 100-203 provided that: "The amendments made by this section [enacting this section and amending section 254o of this title] shall be effective on the date of the enactment of this Act [Dec. 22, 1987]."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 254o, 294f of this title; title 25 section 1816a.

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 242b, 247b-1, 254b, 254c, 254e, 254h, 284n, 256, 263a, 294r, 297n, 300e, 300e-6, 300x-4, 300y-21, 300z-5, 602, 603, 606, 614, 632a, 652, 654, 671, 672, 673, 682, 704, 705, 709, 912, 1301, 1302, 1306, 1308, 1309, 1310, 1315, 1316, 1318, 1320a-1, 1320a-3, 1320a-5, 1320a-7, 1320a-7a, 1320a-7b, 1320b-2, 1320b-3, 1320b-4, 1320b-5, 1320b-7, 1320b-8, 1320c-2, 1320c-10, 1382, 1382b, 1382g, 1382h, 1382i, 1383c, 1395b-1, 1395b-2, 1395i-3, 1395u, 1395v, 1395w-1, 1395x, 1395z, 1395cc, 1395mm, 1395tt, 1395vv, 1395ww, 1395bbb, 1397d, 1766, 1997, 3013, 3026, 3027, 3035b, 6024, 8624, 10805, 11705 of this title; title 7 sections 2012, 2017, 2020, 3178; title 8 sections 1255a, 1522; title 10 sections 1079, 1095; title 12 sections 1701q, 1715w, 1715z-7; title 20 sections 1413, 1481; title 24 section 170a; title 25 sections 1622, 1680c; title 26 section 6103; title 29 sections 1144, 1583, 2215; title 38 sections 622, 629, 4108.

§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch. 531, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960; July 18, 1984, Pub. L. 98-369, div. B, title VI, § 2663(j)(3)(C), 98 Stat. 1171.)

AMENDMENTS

1984—Pub. L. 98-369 struck out "Health, Education, and Welfare" after "Secretary".

1973—Pub. L. 93-233 substituted "disabled individuals" for "permanently and totally disabled individuals" in cl. (1).

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98-369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93-233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as a note under section 1396a of this title.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to

which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (13) and (14) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37), 606(h), or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 614(g) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter or who are qualified severely

under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title, and (C) provide for coordination of the operations under this subchapter with the State's operations under the special supplemental food program for women, infants, and children under section 1786 of this title;

[See main edition for text of (12)]

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

[See main edition for text of (B) and (C)]

(D) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

(E) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395l(a)(3) of this title; and

(F) for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;

[See main edition for text of (14) to (16)]

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in

accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

[See main edition for text of (18) to (24)]

(25) provide—

[See main edition for text of (A) to (D)]

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

[See main edition for text of (i)]

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

[See main edition for text of (i)]

(ii) seek reimbursement from such third party in accordance with subparagraph (B); and

(G) that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);

[See main edition for text of (26) to (29)]

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;

[See main edition for text of (B) and (C), (31)]

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment; and

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time

Secretary to issue regulations, was repealed by Pub. L. 92-603, title II, § 230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Section 248(d) of Pub. L. 90-248 provided that: "The amendment made by section 220(a) of this Act [amending this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam."

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Section 121(b) of Pub. L. 89-97, as amended by section 249D of Pub. L. 92-603, provided that: "No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [subchapter I, IV, X, XIV, or XVI of this chapter] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [this subchapter], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [this subchapter], if such care is (or could be) provided under a State plan approved under title XIX of such Act [this subchapter] by an institution certified under such title XIX [this subchapter]."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 632a, 643, 1315, 1320a-7, 1320a-7a, 1320b-7, 1320c-7, 1395l-3, 1396a, 1396n, 1396o, 1396r, 1396r-1, 1396r-2, 1396r-6 of this title.

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIX § 1904, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 351.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 1316 of this title.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women, or

(ix) individuals provided extended benefits under section 1396r-6 of this title,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l) of this section) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider;

(18) hospice care (as defined in subsection (o) of this section);

(19) case-management services (as defined in section 1396n(g)(2) of this title);

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title); and

(21) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of title 25).

REPORT ON ERRORS IN ELIGIBILITY DETERMINATIONS; ERROR RATE TRANSITION RULES

Section 4607 of Pub. L. 101-508 provided that:

"(a) REPORT.—The Secretary of Health and Human Services shall report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1902(*l*)(1) of the Social Security Act [section 1396a(*l*)(1) of this title] for medical assistance under plans approved under title XIX of such Act [this subchapter]. Such report may include data for medical assistance provided before July 1, 1989.

"(b) ERROR RATE TRANSITION.—There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act [subsec. (u) of this section], payments and expenditures for medical assistance which—

"(1) are attributable to medical assistance for individuals described in subparagraph (A) or (B) of section 1902(*l*)(1) of such Act, and

"(2) are made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the report under subsection (a)."

MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES

Section 4718 of Pub. L. 101-508 provided that:

"(a) IN GENERAL.—For purposes of section 1903(f)(1)(B) [probably means subsec. (f)(1)(B) of this section], for payments made before, on, or after the date of the enactment of this Act (Nov. 5, 1990), a State described in subparagraph (B) may use, in determining the 'highest amount which would ordinarily be paid to a family of the same size' (under the State's plan approved under part A of title IV of such Act [probably means part A of subchapter IV of this chapter]) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

"(b) STATES COVERED.—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act [this subchapter]) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 [Pub. L. 98-369, set out as a note under section 1396a of this title] (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987 [Pub. L. 100-93])."

DAY HABILITATION AND RELATED SERVICES

Section 6411(g) of Pub. L. 101-239 provided that:

"(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

"(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act [subsec. (a) of this section] for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act [section 1396d(a)(9), (13) of this title] on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

"(B) withdraw Federal approval of any such State plan provision.

"(2) REQUIREMENTS FOR REGULATION.—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

"(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

"(B) any requirements respecting such coverage.

"(3) PROSPECTIVE APPLICATION OF REGULATION.—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act [this subchapter] does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State."

NURSE AIDE TRAINING AND EVALUATION PROGRAMS; ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990

Section 6901(b)(5)(B) of Pub. L. 101-239 provided that: "In making payments under section 1903(a)(2)(B) of the Social Security Act [subsec. (a)(2)(B) of this section] for amounts expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act [section 1396r(e)(1) of this title], in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act [this subchapter and subchapter XVIII of this chapter]."

CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES

Section 6901(d)(2) of Pub. L. 101-239 provided that: "During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act [subsec. (a) of this section] for so much of the sums expended under a State plan under title XIX of such Act [this subchapter] as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1315, 1396b-1, 1320b-7, 1320c-7, 1395l-3, 1396a, 1396e, 1396n, 1396o, 1396r, 1396r-1, 1396r-2, 1396r-6, 1396r-7, 1396r-8, 1396t of this title.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

[See main edition for text of (i) to (vii)]

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r-6 of this title, or

(x) individuals described in section 1396a(u)(1) of this title,

but whose income and resources are insufficient to meet all of such cost—

[See main edition for text of (1)]

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (*l*)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (*l*)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (*l*)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

[See main edition for text of (5) to (12)]

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

[See main edition for text of (14) to (19)]

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and [1]

(22) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

(23) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals; [1]

(24) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title).[2]

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded

[1] So in original. The word "and" appearing at end of par. (21) probably should appear at end of par. (23).

[2] So in original. The period probably should be a semicolon.

from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

[*See main edition for text of (b) to (g)*]

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

[*See main edition for text of (B) and (C), (2); (i) to (k)*]

(l) Rural health clinics

(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an [3] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means a [4] entity which—

(i) is receiving a grant under section 254b, 254c, or 256 of this title, or [5]

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b, 254c, or 256 of this title; [6]

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant,

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C. 450f et seq.] [7] applying clause (ii),[7] the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

[*See main edition for text of (m)*]

(n) "Qualified pregnant woman or child" defined

The term "qualified pregnant woman child" means—

[*See main edition for text of (i)*]

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(o) Optional hospice benefits

(1)(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

[*See main edition for text of (B), (2)*]

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

[*See main edition for text of (B)*]

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount described in section 1396a(a)(13)(D) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall provide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

[1] So in original. Probably should be "a".
[2] So in original. Probably should be "an".
[3] So in original. The word "or" probably should not appear.
[4] So in original. The semicolon probably should be ", or".
[5] So in original. Probably should be clause "(iii)". See References in Text note below.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

[*See main edition for text of (C)*]

(2) [*See main edition for text of (A)*]

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title,[8]

[*See main edition for text of (B)*]

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e of this title and section 1395*l*(b) of this title).

[*See main edition for text of (D)*]

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B)[9] or [10] 1396a(a)(10)(E)(iii) of this title of such paragraph [9] any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

[*See main edition for text of (q)*]

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations according to age and health history,

[8] So in original. The comma probably should be a period.
[9] So in original. The words "of such paragraph" probably should follow "subparagraph (B)".
[10] So in original. Probably should be "or section".

by § 17 of the act. For present provisions relating to confidential information, see Chapter 25 of this title.

26-18-2. Definitions.

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

(2) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.

(3) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.

(6) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

History: C. 1953, 26-18-2, enacted by L. **1981, ch. 126, § 17; 1988, ch. 21, § 1.**

Amendment Notes. — The 1988 amendment, effective July 1, 1988, added present Subsections (2) and (3), designated former Subsections (2) and (3) as Subsections (5) and (6), and, in Subsection (6), substituted "has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10" for "the department has determined to be eligible for medical or hospital assistance under the medical programs of the state."

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

26-18-2.1. Division — Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

History: C. 1953, 26-18-2.1, enacted by L. 1988, ch. 21, § 2.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective on July 1, 1988.

26-18-2.2. Director — Appointment — Responsibilities.

The director of the division shall be appointed by the executive director of the department. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) prepare and administer the division's budget; and

(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

26-18-3. Administration of Medicaid program by department — Disciplinary measures and sanctions — Funds collected.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

(3) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(5) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as nonlapsing dedicated credits to be used by the division in accordance with the requirements of that section.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5; 1989, ch. 165, § 1; 1990, ch. 183, § 9.

Amendment Notes. — The 1989 amendment, effective April 24, 1989, added the (a) and (b) designations in Subsection (4); substituted "shall provide, by rule" for "may provide by rule for" and "may not extend" for "shall not extend" in the introductory language of Subsection (4); deleted "or" from the end of Subsection (4)(a); added "and" to the end of Subsection (4)(b); added Subsection (4)(c); made punctuation changes throughout Subsection (4); and added Subsection (5).

The 1990 amendment, effective April 23, 1990, substituted "Human" for "Social" in Subsection (3).

Federal Law. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq. Section 1919 of Title XIX is 42 U.S.C. § 1396r.

(b) The Utah Rules of Evidence apply in judicial proceedings under this section.

History: C. 1953, 63-46b-15, enacted by L. 1987, ch. 161, § 271; 1988, ch. 72, § 25.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, deleted "except that final agency action from informal adjudicative proceedings based on a record shall be reviewed by the district courts on the record according to the standards of Subsection 63-46b-16(4)" at the end in Subsection (1)(a) and made minor stylistic changes.

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

NOTES TO DECISIONS

Function of district court.

Section 63-46b-16(1) provides that all final agency decisions through formal adjudicative proceedings will be reviewed by the Utah Supreme Court or Court of Appeals. Therefore, the district court will no longer function as intermediate appellate court except to review informal adjudicative proceedings de novo pursuant to Subsection (1)(a) of this section. In re Topik, 761 P.2d 32 (Utah Ct. App. 1988).

63-46b-16. Judicial review — Formal adjudicative proceedings.

(1) As provided by statute, the Supreme Court or the Court of Appeals has jurisdiction to review all final agency action resulting from formal adjudicative proceedings.

(2) (a) To seek judicial review of final agency action resulting from formal adjudicative proceedings, the petitioner shall file a petition for review of agency action with the appropriate appellate court in the form required by the appellate rules of the appropriate appellate court.

(b) The appellate rules of the appropriate appellate court shall govern all additional filings and proceedings in the appellate court.

(3) The contents, transmittal, and filing of the agency's record for judicial review of formal adjudicative proceedings are governed by the Utah Rules of Appellate Procedure, except that:

(a) all parties to the review proceedings may stipulate to shorten, summarize, or organize the record;

(b) the appellate court may tax the cost of preparing transcripts and copies for the record:

(i) against a party who unreasonably refuses to stipulate to shorten, summarize, or organize the record; or

(ii) according to any other provision of law.

(4) The appellate court shall grant relief only if, on the basis of the agency's record, it determines that a person seeking judicial review has been substantially prejudiced by any of the following:

(a) the agency action, or the statute or rule on which the agency action is based, is unconstitutional on its face or as applied;

(b) the agency has acted beyond the jurisdiction conferred by any statute;

(c) the agency has not decided all of the issues requiring resolution;

(d) the agency has erroneously interpreted or applied the law;

(e) the agency has engaged in an unlawful procedure or decision-making process, or has failed to follow prescribed procedure;

(f) the persons taking the agency action were illegally constituted as a decision-making body or were subject to disqualification;

(g) the agency action is based upon a determination of fact, made or implied by the agency, that is not supported by substantial evidence when viewed in light of the whole record before the court;

(h) the agency action is:

(i) an abuse of the discretion delegated to the agency by statute;

(ii) contrary to a rule of the agency;

(iii) contrary to the agency's prior practice, unless the agency justifies the inconsistency by giving facts and reasons that demonstrate a fair and rational basis for the inconsistency; or

(iv) otherwise arbitrary or capricious.

History: C. 1953, 63-46b-16, enacted by L. 1987, ch. 161, § 272; 1988, ch. 72, § 26.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, substituted "As provided by statute, the Supreme Court or the Court of Appeals" for "The Supreme Court or other appellate court designated by statute" in Subsection (1); inserted "with the appropriate appellate court" in Subsection (2)(a); and substituted "appellate rules of the appropriate appellate court" for "Utah Rules of Appellate Procedure" in Subsections (2)(a) and (2)(b).

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

NOTES TO DECISIONS

Function of district court.

Subsection (1) provides that all final agency decisions through formal adjudicative proceedings will be reviewed by the Utah Supreme Court or Court of Appeals. Therefore, the district court will no longer function as intermediate appellate court except to review informal adjudicative proceedings de novo pursuant to § 63-46b-15(1)(a). In re Topik, 761 P.2d 32 (Utah Ct. App. 1988).

63-46b-17. Judicial review — Type of relief.

(1) (a) In either the review of informal adjudicative proceedings by the district court or the review of formal adjudicative proceedings by an appellate court, the court may award damages or compensation only to the extent expressly authorized by statute.

(b) In granting relief, the court may:

(i) order agency action required by law;

(ii) order the agency to exercise its discretion as required by law;

(iii) set aside or modify agency action;

(iv) enjoin or stay the effective date of agency action; or

(v) remand the matter to the agency for further proceedings.

(2) Decisions on petitions for judicial review of final agency action are reviewable by a higher court, if authorized by statute.

History: C. 1953, 63-46b-17, enacted by L. 1987, ch. 161, § 273.

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

(j) orders, judgments, and decrees of any court of record over which the Court of Appeals does not have original appellate jurisdiction.

(4) The Supreme Court may transfer to the Court of Appeals any of the matters over which the Supreme Court has original appellate jurisdiction, except:

(a) capital felony convictions or an appeal of an interlocutory order of a court of record involving a charge of a capital felony;

(b) election and voting contests;

(c) reapportionment of election districts;

(d) retention or removal of public officers; and

(e) those matters described in Subsections (3)(a) through (d).

(5) The Supreme Court has sole discretion in granting or denying a petition for writ of certiorari for the review of a Court of Appeals adjudication, but the Supreme Court shall review those cases certified to it by the Court of Appeals under Subsection (3)(b).

(6) The Supreme Court shall comply with the requirements of Title 63, Chapter 46b, in its review of agency adjudicative proceedings.

History: C. 1953, 78-2-2, enacted by L. 1986, ch. 47, § 41; 1987, ch. 161, § 303; 1988, ch. 248, § 5; 1989, ch. 67, § 1; 1992, ch. 127, § 11.

Amendment Notes. — The 1992 amendment, effective April 27, 1992, in Subsection (4), deleted former Subsections (e) and (f), which read: "general water adjudication" and "taxation and revenue; and," respectively, making related changes; redesignated former Subsection (g) as Subsection (e); and made stylistic changes in Subsection (e).

NOTES TO DECISIONS

Cited in State v. Humphrey, 176 Utah Adv. Rep. 8 (1991).

CHAPTER 2a
COURT OF APPEALS

Section
78-2a-3. Court of Appeals jurisdiction.

78-2a-3. Court of Appeals jurisdiction.

(1) The Court of Appeals has jurisdiction to issue all extraordinary writs and to issue all writs and process necessary:

(a) to carry into effect its judgments, orders, and decrees; or

(b) in aid of its jurisdiction.

(2) The Court of Appeals has appellate jurisdiction, including jurisdiction of interlocutory appeals, over:

(a) the final orders and decrees resulting from formal adjudicative proceedings of state agencies or appeals from the district court review of informal adjudicative proceedings of the agencies, except the Public Service Commission, State Tax Commission, Board of State Lands, Board of Oil, Gas, and Mining, and the state engineer;

(b) appeals from the district court review of:

(i) adjudicative proceedings of agencies of political subdivisions of the state or other local agencies; and

(ii) a challenge to agency action under Section 63-46a-12.1;

(c) appeals from the juvenile courts;

(d) appeals from the circuit courts, except those from the small claims department of a circuit court;

(e) interlocutory appeals from any court of record in criminal cases, except those involving a charge of a first degree or capital felony;

(f) appeals from a court of record in criminal cases, except those involving a conviction of a first degree or capital felony;

(g) appeals from orders on petitions for extraordinary writs sought by persons who are incarcerated or serving any other criminal sentence, except petitions constituting a challenge to a conviction of or the sentence for a first degree or capital felony;

(h) appeals from the orders on petitions for extraordinary writs challenging the decisions of the Board of Pardons except in cases involving a first degree or capital felony;

(i) appeals from district court involving domestic relations cases, including, but not limited to, divorce, annulment, property division, child custody, support, visitation, adoption, and paternity;

(j) appeals from the Utah Military Court; and

(k) cases transferred to the Court of Appeals from the Supreme Court.

(3) The Court of Appeals upon its own motion only and by the vote of four judges of the court may certify to the Supreme Court for original appellate review and determination any matter over which the Court of Appeals has original appellate jurisdiction.

(4) The Court of Appeals shall comply with the requirements of Title 63, Chapter 46b, in its review of agency adjudicative proceedings.

History: C. 1953, 78-2a-3, enacted by L. 1986, ch. 47, § 46; 1987, ch. 161, § 304; 1988, ch. 73, § 1; 1988, ch. 210, § 141; 1988, ch. 248, § 8; 1990, ch. 80, § 5; 1990, ch. 224, § 3; 1991, ch. 268, § 22; 1992, ch. 127, § 12.

Amendment Notes. — The 1992 amendment, effective April 27, 1992, added Subsection (2)(h) and redesignated former Subsections (2)(h) through (j) as Subsections (2)(i) through (k).

NOTES TO DECISIONS

Analysis

Habeas corpus proceedings.
Cited.

Habeas corpus proceedings.

Appeal from the dismissal of a habeas corpus petition, in which defendant claimed only that his due process rights were violated at a hearing before the parole board, lay to the Court of Appeals rather than the Supreme Court; the latter has jurisdiction only over direct appeals of first degree or capital felony convictions and appeals in habeas corpus cases where the conviction or sentence is challenged. Padilla v. Utah Bd. of Pardons, 820 P.2d 473 (Utah 1991).

Cited in State v. Humphrey, 176 Utah Adv. Rep. 8 (1991).

MEDICAID INFORMATION BULLETIN

UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
P.O. BOX 16580
SALT LAKE CITY, UTAH 84116-0580

ISSUE DATE	EFFECTIVE DATE	NUMBER
June 20, 1990	July 1, 1990	90-41

SUBJECT

Revised Medical and Surgical Procedures Prior Authorization List (Including Noncovered Services)

TO: Physicians, Osteopaths, Podiatrists, Group Practices

Enclosed for your information is the new Medical and Surgical Procedures Prior Authorization List. This list is effective for dates of service on or after July 1, 1990. Changes in this list are consistent with changes made in the Health Common Procedures Coding System (HCPCS) which includes the CPT Manual. Because the changes were so extensive, it is not possible to list them in detail.

Please review the new list for changes in the following general categories:

- new procedure codes and service definitions to be added for Medicaid coverage;
- procedure codes and service definitions deleted from coverage (for supporting information see Appendix C of the 1990 edition of Physician's Current Procedural Terminology Mnaual);
- changes in prior authorization requirements for selected codes;
- sterilization and consent form requirements, including a new key for clarification;
- new descriptions for some existing procedure codes; and
- codes and service definitions to be noncovered for Medicaid

(OVER)

4598M.31

	PROCEDURE DESCRIPTION	1	2	3	4	5
9379	lower extremity				X	
9999	Unlisted procedure, excision pressure ulcer		X			W
9340	Cryotherapy (CO_2 slush, liquid N_2)				X	
9360	Chemical exfoliation for acne (eg, acne paste, acid)				X	
9380	Electrolysis epilation, each 1/2 hour				X	
9999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue		X			W
9316	Mastopexy				X	
9318	Reduction mammoplasty				X	
9324	Mammoplasty, augmentation: without prosthetic implant				X	
9325	with prosthetic implant				X	
	(For flap or graft, use also appropriate number)					
9340	Immediate insertion of breast prosthesis following mastectomy		X			W
9342	Delayed insertion of breast prosthesis following mastectomy or in reconstruction		X			W
9350	Nipple/areola reconstruction				X	
9355	Correction of inverted nipples				X	
9360	Breast reconstruction with muscle or myocutaneous flap		X			W
	(Use also code number for specific flap)					

Effective Date
July 1, 1990

Column 1 - Requires prior authorization for inpatient service
Column 2 - Requires prior authorization always
Column 3 - Requires prior authorization and consent form for specified procedures
Column 4 - Not authorized for Medicaid coverage
Column 5 - Key to prior authorization requirement:
T - Telephone prior authorization only.
W - Written prior authorization request only.
TW - Telephone prior authorization request followed by written documentation for the request.

	PROCEDURE DESCRIPTION	1	2	3	4	5
295	Reduction of masseter muscle (eg, treatment of benign masseteric hypertrophy); extraoral approach		X			W
296	intraoral approach		X			W
480	Uncomplicated treatment of Temporomandibular dislocation, Initial or Subsequent				X	
490	Open treatment of Temporomadibular dislocation				X	
499	Unlisted orthopedic proceoure, head		X			W
899	Unlisted procedure, neck or thorax		X			W
140	Reconstruction of spine with bone graft (autograft, allograft and/or methyimethacryiate) following resection of single vertebral body; cervical		X			W
141	thoracic		X			W
142	lumbar		X			W
145	Reconstruction of spine following vertebral body resection, each additional vertebral body		X			W
148	Harvesting of bone autograft for vertebral reconstruction following vertebral corpectomy		X			W
150	Reconstruction of spine with prefabricated prosthetic replacement following resection of one or more vertebral bodies; cervical		X			W
151	thoracic		X			W
152	lumbar		X			W

Effective Date
July 1, 1990

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	PROCEDURE DESCRIPTION	1	2	3	4	5
364	Breast reconstruction with free flap		X			W
	(Use also code number for specific flap)					
1366	Breast Reconstruction with other technique				X	
	(For microsurgical technique, add modifier -20 or 09920)					
	(For insertion of prosthesis, use also 19340 or 19342)					
9370	Open periprosthetic capsulotomy, breast		X			W
9371	Periprosthetic capsulectomy, breast		X			W
19380	Revision of reconstructed breast		X			W
19396	Preparation of moulage for custom breast implant				X	
19499	Unlisted procedure, breast		X			W
20974	Electrical stimulation for bone		X			T
20975	invasive (operative)		X			T
20976	percutaneous insertion of electrodes		X			T
20999	Unlisted procedure, musculoskeletal system, general		X			W
21010	Arthrotomy, tempromandibular joint;		X			W
21050	Condylectomy, Temporomandibular joint (separate procedure)		X			W
21060	Meniscetomy, Partial or Complete, Temporomandibular Joint (Separate Procedure)		X			W

Effective Date
July 1, 1990

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CERTIFICATE OF MAILING

I certify that four true and correct copies of the foregoing brief were hand delivered to the following office on the 10th day of March, 1993.

Jan Graham
Attorney General of Utah
Douglas W. Springmeyer
Assistant Attorney General
Human Services Division
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P.O. Box 45011
Salt Lake City, Utah 84145

DATED this 10th day of March, 1993.

Steven Elmo Averett